

ATTACHMENT 4

Health Care Providers Universal Service Funding Request and Certification Form

The Deadline to submit this Form is the June 30th End of the Funding Year.

Estimated time per response: 3 hours

Read instructions thoroughly before completing this form. Failure to comply may cause delayed or denied funding.**Block 1: HCP Information**

1 HCP Name Brevig Mission Clinic	2 HCP Number 10673
3 Form 465 Application # 43137988	4 Consortium Name (If any)

Block 2: Bill Payer Information

5 Billed Entity Name Brevig Mission Clinic	6 Billed Entity FCC RN 0014835128
7 Contact Name Richard B Wideman	
8 Address Line 1 4311 Clarence Rd.	
9 Address Line 2	
10 City Brevig Mission	11 State AK 12 Zip 99785
13 Contact Phone # (907) 443-3272	14 Fax # 15 E-Mail rwideman@nshcorp.org

Block 3: Funding Year Information

16 Funding Year - Check only one box		
<input checked="" type="checkbox"/> Year 2013 (7/1/2013-6/30/2014)	<input type="checkbox"/> Year 2014 (7/1/2014-6/30/2015)	<input type="checkbox"/> Year 2015 (7/1/2015-6/30/2016)

Block 4: Service Information

17 Type of Service & Circuit Bandwidth (Enclose documentation.) Satellite Service 2 Mbps	
18 Total Billed Miles 0	19 Maximum Allowable Distance (From Form 465) 594
20 Percentage of HCP's service used for the provision of health care. 100 (If less than 100%, please explain.) If the HCP indicated it is a part-time eligible entity (on Form 465), describe method of allocating prorated support.	

Connection Information	Carrier A	Carrier B	Carrier C	Carrier D
21 Service Provider Name	GCI Communication Corp			
22 Service Provider Identification Number (SPIN)	143001199			
23 Service Provider Contact Person Name	Steve Walker			
24 Service Provider Contact Person's Phone #	(907) 868-6416			
25 Service Provider Contact Person Email	swalker@gci.com			
26 Circuit Start Location	4311 Clarence Rd. Brevig Mission, AK 99785			
27 Circuit Termination Location	1000 Kruschek Ave. Nome, AK 99762			
28 Billing Account Number	RH000220008			
29 Tariff, Contract or other document reference number	HC-302			
30 Date Contract Signed or Date HCP Selected Carrier	09-Aug-2010			
31 Contract Expiration Date (mm/dd/yyyy or NA if MTM)	09-Aug-2015			
32 Service Installation Date	24-Jul-2013			
33 Actual Rural Rate per Month (Enclose Documentation)	10161.00			
34 If you are a consortium member OR have multiple carriers, please attach a Circuit Diagram to show how the sites interconnect and which carrier(s) provides each circuit segment. Circuit Diagram included: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
35 Are you a mobile rural health care provider? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, see instructions and attach a list of all sites to be served.				

IF YOU ARE REQUESTING SUPPORT FOR MILEAGE-BASED CHARGES, COMPLETE BLOCK 5 ONLY AND SKIP BLOCK 6. (PLEASE SEE INSTRUCTIONS). IF YOU ARE REQUESTING SUPPORT BASED ON URBAN/RURAL RATE COMPARISON, SKIP BLOCK 5 AND COMPLETE ONLY BLOCK 6. YOUR APPLICATION CANNOT BE PROCESSED IF BOTH BLOCKS ARE COMPLETED.				
Block 5: Mileage-based Charge Discount Request				
Complete this block if you are seeking support for mileage (distance-based) charges only. Do not enter any other charges in this block. You may need to ask your service provider representative to provide this information.				
36 Billed Circuit Miles				
37 Monthly Mileage Charges (Exclude Channel Termination chgs, etc.)				
38 Cost per Mile per Month				
If Line 33 equals Line 37, please ensure that ONLY mileage-related charges are included in Line 37. (See instructions.)				
Block 6: Comprehensive Rate Comparison Request				
Complete Block 6 if you have not completed Block 5 and are requesting support for all elements of your telecommunications service necessary for the provision of health care. The information in this block will establish the difference between the urban and rural rates for your requested service. Please call RHCD at 1-800-229-5476 if you need assistance.				
39 One-time Urban Rate Charge (in selected large city)	0			
40 One-time Rural Rate Charge (in city where HCP is located)	0			
41 Monthly Urban Rate (in selected large city). From RHCD web site: <input type="checkbox"/> or Other rate documentation attached: <input checked="" type="checkbox"/>	140.00			
If your circuit includes charges for mileage over the Maximum Allowable Dist., (Line 19), please complete Lines 42 to 44. Otherwise, skip to Block 7.				
42 Billed Circuit Miles				
43 Monthly Mileage Based Charges				
44 Cost per Mile per Month				
Block 7: Bid Documentation				
45 Did you receive any bids in response to the Form 465 Request for Services posted on the RHCD website? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If you checked yes, copies of the bids MUST be mailed to RHCD.				
Block 8: Certification				
46 <input checked="" type="checkbox"/> I certify that the above named entity has considered all bids received and selected the most cost-effective method of providing the requested service or services. The "most cost-effective service" is defined in the Universal Service Order as the service available at the lowest cost after consideration of the features, quality of transmission, reliability, and other factors that the health care provider deems necessary for the service to adequately transmit the health care services required by the health care provider.				
47 <input checked="" type="checkbox"/> Pursuant to 47 C.F.R. Secs. 54.601 and 54.603, I certify that the HCP or consortium that I am representing satisfies all of the requirements herein and will abide by all of the relevant requirements, including all applicable FCC rules, with respect to universal service benefits provided under 47 U.S.C. Sec. 254. I understand that any letter from RHCD that erroneously states that funds will be made available for the benefit of the applicant may be subject to rescission.				
48 <input checked="" type="checkbox"/> I hereby certify that the billed entity will maintain complete billing records for the service for five years.				
49 <input checked="" type="checkbox"/> I certify that I am authorized to submit this request on behalf of the above-named Billed Entity and HCP, and that I have examined this form and attachments and that to the best of my knowledge, information, and belief, all statements of fact contained herein are true.				
50 Signature Electronically signed	51 Date		14-Nov-2013	
52 Printed name of authorized person	Richard B Wideman		53 Title or position of authorized person TeleHealth Coordinat	
54 Employer of authorized person	Norton Sound Health Corporation		55 Employer's FCC RN 0014835128	

Please remember:

- You must submit one Form 466 for **each service** (i.e., circuit) for which you request reduced rates. For example:
 - If you are requesting reduced rates for **two** T1 lines, you must submit **two** Forms 466.
 - If you are requesting reduced rates for **two** ISDN lines & **one** Frame Relay line, you must submit **three** Forms 466.
- If the service described on this form is subject to the **28-day competitive bidding requirement**, do not select a carrier or complete the Form 466 before or during the 28-day posting period.
- You must provide evidence of the urban rate if you have completed Block 6 and have not used the urban rates from the website.
- This form, attachments, and supporting documents should be combined in one envelope and sent to the RHCD.
- If the service described on this form changes (e.g., rate change) during the funding year, **you must notify RHCD immediately** and submit a revised Form 466.
- If you have any questions, call RHCD at 1-800-229-5476.

Persons willfully making false statements on this form can be punished by fine or forfeiture under the Communications Act, 47 U.S.C. Secs. 502, 503(b), or fine or imprisonment under Title 18 of the United States Code, 18 U.S.C. Sec. 1001.

FCC NOTICE FOR INDIVIDUALS REQUIRED BY THE PRIVACY ACT AND THE PAPERWORK REDUCTION ACT

Part 3 of the Commission's Rules authorize the FCC to request the information on this form. The data reported will be used to ensure that health care providers have selected the most cost-effective method of providing the requested services as set forth in 47 C.F.R. § 54.603(b)(4). The information will be used by the Universal Service Administrative Company and/or the staff of the Federal Communications Commission, to evaluate this form, to provide information for enforcement and rulemaking proceedings and to maintain a current inventory of applicants, health care providers, billed entities, and service providers. No authorization can be granted unless all information requested is provided. Failure to provide all requested information will delay the processing of the application or result in the application being returned without action. Information requested by this form will be available for public inspection. Your response is required to obtain the requested authorization.

The public reporting for this collection of information is estimated to average 3 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the required data, and completing and reviewing the collection of information. If you have any comments on this burden estimate, or how we can improve the collection and reduce the burden it causes you, please write to the Federal Communications Commission, AMD-PERF, Paperwork Reduction Act Project (3060-0804), Washington, DC 20554. We will also accept your comments regarding the Paperwork Reduction Act aspects of this collection via the Internet if you send them to pra@fcc.gov. PLEASE DO NOT SEND YOUR RESPONSE TO THIS ADDRESS.

Remember - You are not required to respond to a collection of information sponsored by the Federal government, and the government may not conduct or sponsor this collection, unless it displays a currently valid OMB control number or if we fail to provide you with this notice. This collection has been assigned an OMB control number of 3060-0804.

THE FOREGOING NOTICE IS REQUIRED BY THE PRIVACY ACT OF 1974, PUBLIC LAW 93-579, DECEMBER 31, 1974, 5 U.S.C. 552a(e)(3) AND THE PAPERWORK REDUCTION ACT OF 1995, PUBLIC LAW 104-13, OCTOBER 1, 1995, 44 U.S.C. SECTION 3507.

This form should be submitted to:
Rural Health Care Division
30 Lanidex Plaza West, P.O.Box 685
Parsippany NJ 07054-0685

Health Care Providers Universal Service Funding Request and Certification Form

The Deadline to submit this Form is the June 30th End of the Funding Year.

Estimated time per response: 3 hours

Read instructions thoroughly before completing this form. Failure to comply may cause delayed or denied funding.**Block 1: HCP Information**

1 HCP Name Elim Clinic	2 HCP Number 10674
3 Form 465 Application # 43138001	4 Consortium Name (If any)

Block 2: Bill Payer Information

5 Billed Entity Name Elim Clinic	6 Billed Entity FCC RN 0014835128
7 Contact Name Richard B Wideman	
8 Address Line 1 69 Old Airport Rd.	
9 Address Line 2	
10 City Elim	11 State AK 12 Zip 99739
13 Contact Phone # (907) 443-3272	14 Fax # 15 E-Mail rwideman@nshcorp.org

Block 3: Funding Year Information

16 Funding Year - Check only one box		
<input checked="" type="checkbox"/> Year 2013 (7/1/2013-6/30/2014)	<input type="checkbox"/> Year 2014 (7/1/2014-6/30/2015)	<input type="checkbox"/> Year 2015 (7/1/2015-6/30/2016)

Block 4: Service Information

17 Type of Service & Circuit Bandwidth (Enclose documentation.)	Satellite Service 2 Mbps
18 Total Billed Miles 0	19 Maximum Allowable Distance (From Form 465) 461
20 Percentage of HCP's service used for the provision of health care. 100 (If less than 100%, please explain.) If the HCP indicated it is a part-time eligible entity (on Form 465), describe method of allocating prorated support.	

Connection Information	Carrier A	Carrier B	Carrier C	Carrier D
21 Service Provider Name	GCI Communication Corp			
22 Service Provider Identification Number (SPIN)	143001199			
23 Service Provider Contact Person Name	Steve Walker			
24 Service Provider Contact Person's Phone #	(907) 868-6416			
25 Service Provider Contact Person Email	swalker@gci.com			
26 Circuit Start Location	69 Old Airport Rd Elim, AK 99739			
27 Circuit Termination Location	1000 Greg Kruschak Ave. Nome, AK 99762			
28 Billing Account Number	RH000220008			
29 Tariff, Contract or other document reference number	HC-302			
30 Date Contract Signed or Date HCP Selected Carrier	08-Aug-2010			
31 Contract Expiration Date (mm/dd/yyyy or NA if MTM)	08-Aug-2015 - N/A			
32 Service Installation Date	01-Jul-2013			
33 Actual Rural Rate per Month (Enclose Documentation)	10181.00			
34 If you are a consortium member OR have multiple carriers, please attach a Circuit Diagram to show how the sites interconnect and which carrier(s) provides each circuit segment. Circuit Diagram included: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
35 Are you a mobile rural health care provider? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, see instructions and attach a list of all sites to be served.				

IF YOU ARE REQUESTING SUPPORT FOR MILEAGE-BASED CHARGES, COMPLETE BLOCK 5 ONLY AND SKIP BLOCK 6. (PLEASE SEE INSTRUCTIONS). IF YOU ARE REQUESTING SUPPORT BASED ON URBAN/RURAL RATE COMPARISON, SKIP BLOCK 5 AND COMPLETE ONLY BLOCK 6. YOUR APPLICATION CANNOT BE PROCESSED IF BOTH BLOCKS ARE COMPLETED.

Block 5: Mileage-based Charge Discount Request

Complete this block if you are seeking support for mileage (distance-based) charges only. Do not enter any other charges in this block. You may need to ask your service provider representative to provide this information.

36 Billed Circuit Miles				
37 Monthly Mileage Charges (Exclude Channel Termination chgs, etc.)				
38 Cost per Mile per Month				

If Line 33 equals Line 37, please ensure that ONLY mileage-related charges are included in Line 37. (See instructions.)

Block 6: Comprehensive Rate Comparison Request

Complete Block 6 if you have not completed Block 5 and are requesting support for all elements of your telecommunications service necessary for the provision of health care. The information in this block will establish the difference between the urban and rural rates for your requested service. Please call RHCD at 1-800-229-5476 if you need assistance.

39 One-time Urban Rate Charge (in selected large city)	0			
40 One-time Rural Rate Charge (in city where HCP is located)	0			
41 Monthly Urban Rate (in selected large city). From RHCD web site: <input type="checkbox"/> or Other rate documentation attached: <input checked="" type="checkbox"/>	140.00			

If your circuit includes charges for mileage over the Maximum Allowable Dist., (Line 19), please complete Lines 42 to 44. Otherwise, skip to Block 7.

42 Billed Circuit Miles				
43 Monthly Mileage Based Charges				
44 Cost per Mile per Month				

Block 7: Bid Documentation

45 Did you receive any bids in response to the Form 465 Request for Services posted on the RHCD website? ☐ Yes ☒ No
If you checked yes, copies of the bids MUST be mailed to RHCD.

Block 8: Certification

46 <input checked="" type="checkbox"/> I certify that the above named entity has considered all bids received and selected the most cost-effective method of providing the requested service or services. The "most cost-effective service" is defined in the Universal Service Order as the service available at the lowest cost after consideration of the features, quality of transmission, reliability, and other factors that the health care provider deems necessary for the service to adequately transmit the health care services required by the health care provider.	
47 <input checked="" type="checkbox"/> Pursuant to 47 C.F.R. Secs. 54.601 and 54.603, I certify that the HCP or consortium that I am representing satisfies all of the requirements herein and will abide by all of the relevant requirements, including all applicable FCC rules, with respect to universal service benefits provided under 47 U.S.C. Sec. 254. I understand that any letter from RHCD that erroneously states that funds will be made available for the benefit of the applicant may be subject to rescission.	
48 <input checked="" type="checkbox"/> I hereby certify that the billed entity will maintain complete billing records for the service for five years.	
49 <input checked="" type="checkbox"/> I certify that I am authorized to submit this request on behalf of the above-named Billed Entity and HCP, and that I have examined this form and attachments and that to the best of my knowledge, information, and belief, all statements of fact contained herein are true.	
50 Signature Electronically signed	51 Date 21-Nov-2013
52 Printed name of authorized person Richard B Wideman	53 Title or position of authorized person TeleHealth Coordinator
54 Employer of authorized person Norton Sound Health Corporation	55 Employer's FCC RN 0014835128

Please remember:

- ♦ You must submit one Form 466 for **each service** (i.e., circuit) for which you request reduced rates. For example:
 - If you are requesting reduced rates for **two** T1 lines, you must submit **two** Forms 466.
 - If you are requesting reduced rates for **two** ISDN lines & **one** Frame Relay line, you must submit **three** Forms 466.
- ♦ **If the service described on this form is subject to the 28-day competitive bidding requirement, do not select a carrier or complete the Form 466 before or during the 28-day posting period.**
- ♦ **You must provide evidence of the urban rate if you have completed Block 6 and have not used the urban rates from the website.**
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Rural Health Care Division
30 Lanidex Plaza West, P.O.Box 685
Parsippany NJ 07054-0685

Health Care Providers Universal Service Funding Request and Certification Form

The Deadline to submit this Form is the June 30th End of the Funding Year.

Estimated time per response: 3 hours

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1 HCP Name Gambell Clinic	2 HCP Number 10675
3 Form 465 Application #43137998	4 Consortium Name (If any)

Block 2: Bill Payer Information

5 Billed Entity Name Gambell Clinic	6 Billed Entity FCC RN 0014835128
7 Contact Name Richard B Widman	
8 Address Line 1 190 Clinic Rd.	
9 Address Line 2	
10 City Gambell	11 State AK 12 Zip 99742
13 Contact Phone # (907) 443-3272	14 Fax # 15 E-Mail rwideman@nshcorp.org

Block 3: Funding Year Information

16 Funding Year - Check only one box		
<input checked="" type="checkbox"/> Year 2013 (7/1/2013-6/30/2014)	<input type="checkbox"/> Year 2014 (7/1/2014-6/30/2015)	<input type="checkbox"/> Year 2015 (7/1/2015-6/30/2016)

Block 4: Service Information

17 Type of Service & Circuit Bandwidth (Enclose documentation.) Satellite Service 2 Mbps	
18 Total Billed Miles 0	19 Maximum Allowable Distance (From Form 465) 723
20 Percentage of HCP's service used for the provision of health care. 100 (If less than 100%, please explain.) If the HCP indicated it is a part-time eligible entity (on Form 465), describe method of allocating prorated support.	

Connection Information	Carrier A	Carrier B	Carrier C	Carrier D
21 Service Provider Name	GCI Communication Corp			
22 Service Provider Identification Number (SPIN)	143001199			
23 Service Provider Contact Person Name	Steve Walker			
24 Service Provider Contact Person's Phone #	(907) 868-6416			
25 Service Provider Contact Person Email	swalker@gci.com			
26 Circuit Start Location	190 Clinic Rd. Gambell, AK 99742			
27 Circuit Termination Location	1000 Greg Kruschek Ave Nemo, AK 99762			
28 Billing Account Number	RH000220008			
29 Tariff, Contract or other document reference number	HC-302			
30 Date Contract Signed or Date HCP Selected Carrier	08-Aug-2010			
31 Contract Expiration Date (mm/dd/yyyy or NA if MTM)	08-Aug-2015			
32 Service Installation Date	17-Jul-2013			
33 Actual Rural Rate per Month (Enclose Documentation)	10524.64			
34 If you are a consortium member OR have multiple carriers, please attach a Circuit Diagram to show how the sites interconnect and which carrier(s) provides each circuit segment. Circuit Diagram included: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
35 Are you a mobile rural health care provider? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, see instructions and attach a list of all sites to be served.				

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39 One-time Urban Rate Charge (in selected large city)	0.00			
40 One-time Rural Rate Charge (in city where HCP is located)	0.00			
41 Monthly Urban Rate (in selected large city). From RHCD web site: <input type="checkbox"/> or Other rate documentation attached: <input checked="" type="checkbox"/>	140.00			

If your circuit includes charges for mileage over the Maximum Allowable Dist., (Line 19), please complete Lines 42 to 44. Otherwise, skip to Block 7.

42 Billed Circuit Miles				
43 Monthly Mileage Based Charges				
44 Cost per Mile per Month				

Block 7: Bid Documentation

45 Did you receive any bids in response to the Form 465 Request for Services posted on the RHCD website? ☐ Yes ☒ No
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50 Signature Electronically signed	51 Date 06-Dec-2013
52 Printed name of authorized person Richard B Wideman	53 Title or position of authorized person TeleHealth Coordinator
54 Employer of authorized person Norton Sound Health Corporation	55 Employer's FCC RN 0014835128

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1 HCP Name Golovin Clinic	2 HCP Number 10676
3 Form 465 Application # 43137991	4 Consortium Name (If any)

Block 2: Bill Payer Information

5 Billed Entity Name Golovin Clinic	6 Billed Entity FCC RN 0014835128
7 Contact Name Richard B Wideman	
8 Address Line 1 39 Punguk St	
9 Address Line 2	
10 City Golovin	11 State AK 12 Zip 99762
13 Contact Phone # (907) 443-3272	14 Fax # 15 E-Mail rwideman@nshcorp.org

Block 3: Funding Year Information

16 Funding Year - Check only one box		
<input checked="" type="checkbox"/> Year 2013 (7/1/2013-6/30/2014)	<input type="checkbox"/> Year 2014 (7/1/2014-6/30/2015)	<input type="checkbox"/> Year 2015 (7/1/2015-6/30/2016)

Block 4: Service Information

17 Type of Service & Circuit Bandwidth (Enclose documentation.)	Satellite Service 2 Mbps
18 Total Billed Miles 0	19 Maximum Allowable Distance (From Form 465) 479
20 Percentage of HCP's service used for the provision of health care. 100 (If less than 100%, please explain.)	
If the HCP indicated it is a part-time eligible entity (on Form 465), describe method of allocating prorated support.	

Connection Information	Carrier A	Carrier B	Carrier C	Carrier D
21 Service Provider Name	GCI Communication Corp			
22 Service Provider Identification Number (SPIN)	143001199			
23 Service Provider Contact Person Name	Steve Walker			
24 Service Provider Contact Person's Phone #	(907) 868-6416			
25 Service Provider Contact Person Email	swalker@gci.com			
26 Circuit Start Location	39 Punguk St Golovin, AK 99762			
27 Circuit Termination Location	1000 Greg Kruschek Ave Nome, AK 99762			
28 Billing Account Number	RH000220008			
29 Tariff, Contract or other document reference number	HC-302			
30 Date Contract Signed or Date HCP Selected Carrier	09-Aug-2010			
31 Contract Expiration Date (mm/dd/yyyy or NA if MTM)	08-Aug-2015			
32 Service Installation Date	01-Jul-2013			
33 Actual Rural Rate per Month (Enclose Documentation)	10181.00			
34 If you are a consortium member OR have multiple carriers, please attach a Circuit Diagram to show how the sites interconnect and which carrier(s) provides each circuit segment. Circuit Diagram included: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
35 Are you a mobile rural health care provider? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, see instructions and attach a list of all sites to be served.				

IF YOU ARE REQUESTING SUPPORT FOR MILEAGE-BASED CHARGES, COMPLETE BLOCK 5 ONLY AND SKIP BLOCK 6. (PLEASE SEE INSTRUCTIONS). IF YOU ARE REQUESTING SUPPORT BASED ON URBAN/RURAL RATE COMPARISON, SKIP BLOCK 5 AND COMPLETE ONLY BLOCK 6. YOUR APPLICATION CANNOT BE PROCESSED IF BOTH BLOCKS ARE COMPLETED.				
Block 5: Mileage-based Charge Discount Request				
Complete this block if you are seeking support for mileage (distance-based) charges only. Do not enter any other charges in this block. You may need to ask your service provider representative to provide this information.				
36 Billed Circuit Miles				
37 Monthly Mileage Charges (Exclude Channel Termination chgs, etc.)				
38 Cost per Mile per Month				
If Line 33 equals Line 37, please ensure that ONLY mileage-related charges are included in Line 37. (See instructions.)				
Block 6: Comprehensive Rate Comparison Request				
Complete Block 6 if you have not completed Block 5 and are requesting support for all elements of your telecommunications service necessary for the provision of health care. The information in this block will establish the difference between the urban and rural rates for your requested service. Please call RHCD at 1-800-229-5476 if you need assistance.				
39 One-time Urban Rate Charge (in selected large city)	0.00			
40 One-time Rural Rate Charge (in city where HCP is located)	0			
41 Monthly Urban Rate (in selected large city). From RHCD web site: <input type="checkbox"/> or Other rate documentation attached: <input checked="" type="checkbox"/>	140.00			
If your circuit includes charges for mileage over the Maximum Allowable Dist., (Line 19), please complete Lines 42 to 44. Otherwise, skip to Block 7.				
42 Billed Circuit Miles				
43 Monthly Mileage Based Charges				
44 Cost per Mile per Month				
Block 7: Bid Documentation				
45 Did you receive any bids in response to the Form 465 Request for Services posted on the RHCD website? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If you checked yes, copies of the bids MUST be mailed to RHCD.				
Block 8: Certification				
46 <input checked="" type="checkbox"/> I certify that the above named entity has considered all bids received and selected the most cost-effective method of providing the requested service or services. The "most cost-effective service" is defined in the Universal Service Order as the service available at the lowest cost after consideration of the features, quality of transmission, reliability, and other factors that the health care provider deems necessary for the service to adequately transmit the health care services required by the health care provider.				
47 <input checked="" type="checkbox"/> Pursuant to 47 C.F.R. Secs. 54.601 and 54.603, I certify that the HCP or consortium that I am representing satisfies all of the requirements herein and will abide by all of the relevant requirements, including all applicable FCC rules, with respect to universal service benefits provided under 47 U.S.C. Sec. 254. I understand that any letter from RHCD that erroneously states that funds will be made available for the benefit of the applicant may be subject to rescission.				
48 <input checked="" type="checkbox"/> I hereby certify that the billed entity will maintain complete billing records for the service for five years.				
49 <input checked="" type="checkbox"/> I certify that I am authorized to submit this request on behalf of the above-named Billed Entity and HCP, and that I have examined this form and attachments and that to the best of my knowledge, information, and belief, all statements of fact contained herein are true.				
50 Signature Electronically signed		51 Date 06-Dec-2013		
52 Printed name of authorized person Richard B Wideman		53 Title or position of authorized person TeleHealth Coordinator		
54 Employer of authorized person Norton Sound Health Corporation		55 Employer's FCC RN 0014835128		

Please remember:

- You must submit one Form 466 for **each service** (i.e., circuit) for which you request reduced rates. For example:
 - If you are requesting reduced rates for **two** T1 lines, you must submit **two** Forms 466.
 - If you are requesting reduced rates for **two** ISDN lines & **one** Frame Relay line, you must submit **three** Forms 466.
- If the service described on this form is subject to the **28-day competitive bidding requirement**, do not select a carrier or complete the Form 466 before or during the 28-day posting period.
- You must provide evidence of the urban rate if you have completed Block 6 and have not used the urban rates from the website.
- This form, attachments, and supporting documents should be combined in one envelope and sent to the RHCD.
- If the service described on this form changes (e.g., rate change) during the funding year, you must notify RHCD immediately and submit a revised Form 466.
- If you have any questions, call RHCD at 1-800-229-5476.

Persons willfully making false statements on this form can be punished by fine or forfeiture under the Communications Act, 47 U.S.C. Secs. 502, 503(b), or fine or imprisonment under Title 18 of the United States Code, 18 U.S.C. Sec. 1001.

FCC NOTICE FOR INDIVIDUALS REQUIRED BY THE PRIVACY ACT AND THE PAPERWORK REDUCTION ACT

Part 3 of the Commission's Rules authorize the FCC to request the information on this form. The data reported will be used to ensure that health care providers have selected the most cost-effective method of providing the requested services as set forth in 47 C.F.R. § 54.603(b)(4). The information will be used by the Universal Service Administrative Company and/or the staff of the Federal Communications Commission, to evaluate this form, to provide information for enforcement and rulemaking proceedings and to maintain a current inventory of applicants, health care providers, billed entities, and service providers. No authorization can be granted unless all information requested is provided. Failure to provide all requested information will delay the processing of the application or result in the application being returned without action. Information requested by this form will be available for public inspection. Your response is required to obtain the requested authorization.

The public reporting for this collection of information is estimated to average 3 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the required data, and completing and reviewing the collection of information. If you have any comments on this burden estimate, or how we can improve the collection and reduce the burden it causes you, please write to the Federal Communications Commission, AMD-PER, Paperwork Reduction Act Project (3060-0804), Washington, DC 20554. We will also accept your comments regarding the Paperwork Reduction Act aspects of this collection via the Internet if you send them to pra@fcc.gov. PLEASE DO NOT SEND YOUR RESPONSE TO THIS ADDRESS.

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THE FOREGOING NOTICE IS REQUIRED BY THE PRIVACY ACT OF 1974, PUBLIC LAW 93-579, DECEMBER 31, 1974, 5 U.S.C. 552a(e)(3) AND THE PAPERWORK REDUCTION ACT OF 1995, PUBLIC LAW 104-13, OCTOBER 1, 1995, 44 U.S.C. SECTION 3507.

This form should be submitted to:
Rural Health Care Division
30 Lanidex Plaza West, P.O.Box 685
Parsippany NJ 07054-0685

Health Care Providers Universal Service
Funding Request and Certification Form

The Deadline to submit this Form is the June 30th End of the Funding Year.

Estimated time per response: 3 hours

Read instructions thoroughly before completing this form. Failure to comply may cause delayed or denied funding.**Block 1: HCP Information**

1 HCP Name Koyuk Clinic	2 HCP Number 10677
3 Form 465 Application # 43137993	4 Consortium Name (If any)

Block 2: Bill Payer Information

5 Billed Entity Name Koyuk Clinic	6 Billed Entity FCC RN 0014835128
7 Contact Name Richard B Wideman	
8 Address Line 1 70 Poplar St	
9 Address Line 2	
10 City Koyuk	11 State AK 12 Zip 99753
13 Contact Phone # (907) 443-3272	14 Fax # 15 E-Mail rwideman@nshcorp.org

Block 3: Funding Year Information

16 Funding Year - Check only one box
<input checked="" type="checkbox"/> Year 2013 (7/1/2013-6/30/2014) <input type="checkbox"/> Year 2014 (7/1/2014-6/30/2015) <input type="checkbox"/> Year 2015 (7/1/2015-6/30/2016)

Block 4: Service Information

17 Type of Service & Circuit Bandwidth (Enclose documentation.) Satellite Service 2 Mbps	
18 Total Billed Miles 0	19 Maximum Allowable Distance (From Form 465) 442
20 Percentage of HCP's service used for the provision of health care. 100 (If less than 100%, please explain.) If the HCP indicated it is a part-time eligible entity (on Form 465), describe method of allocating prorated support. 	

Connection Information	Carrier A	Carrier B	Carrier C	Carrier D
21 Service Provider Name	GCI Communication Corp			
22 Service Provider Identification Number (SPIN)	143001199			
23 Service Provider Contact Person Name	Steve Walker			
24 Service Provider Contact Person's Phone #	(907) 868-6418			
25 Service Provider Contact Person Email	swalker@gci.com			
26 Circuit Start Location	70 Poplar St Koyuk, AK 99753			
27 Circuit Termination Location	11000 Greg Kruscheik Ave Nome, AK 99762			
28 Billing Account Number	RH000220006			
29 Tariff, Contract or other document reference number	HC-302			
30 Date Contract Signed or Date HCP Selected Carrier	09-Aug-2010			
31 Contract Expiration Date (mm/dd/yyyy or NA if MTM)	08-Aug-2015			
32 Service Installation Date	01-Jul-2013			
33 Actual Rural Rate per Month (Enclose Documentation)	10181.00			
34 If you are a consortium member OR have multiple carriers, please attach a Circuit Diagram to show how the sites interconnect and which carrier(s) provides each circuit segment. Circuit Diagram included: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
35 Are you a mobile rural health care provider? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, see instructions and attach a list of all sites to be served.				

IF YOU ARE REQUESTING SUPPORT FOR MILEAGE-BASED CHARGES, COMPLETE BLOCK 5 ONLY AND SKIP BLOCK 6. (PLEASE SEE INSTRUCTIONS). IF YOU ARE REQUESTING SUPPORT BASED ON URBAN/RURAL RATE COMPARISON, SKIP BLOCK 5 AND COMPLETE ONLY BLOCK 6. YOUR APPLICATION CANNOT BE PROCESSED IF BOTH BLOCKS ARE COMPLETED.

Block 5: Mileage-based Charge Discount Request

Complete this block if you are seeking support for mileage (distance-based) charges only. Do not enter any other charges in this block. You may need to ask your service provider representative to provide this information.

36 Billed Circuit Miles				
37 Monthly Mileage Charges (Exclude Channel Termination chgs, etc.)				
38 Cost per Mile per Month				

If Line 33 equals Line 37, please ensure that **ONLY** mileage-related charges are included in Line 37. (See instructions.)

Block 6: Comprehensive Rate Comparison Request

Complete Block 6 if you have not completed Block 5 and are requesting support for all elements of your telecommunications service necessary for the provision of health care. The information in this block will establish the difference between the urban and rural rates for your requested service. Please call RHCD at 1-800-229-5476 if you need assistance.

39 One-time Urban Rate Charge (in selected large city)	0.00			
40 One-time Rural Rate Charge (in city where HCP is located)	0			
41 Monthly Urban Rate (in selected large city). From RHCD web site: <input type="checkbox"/> or Other rate documentation attached: <input checked="" type="checkbox"/>	140.00			

If your circuit includes charges for mileage over the Maximum Allowable Dist., (Line 19), please complete Lines 42 to 44. Otherwise, skip to Block 7.

42 Billed Circuit Miles				
43 Monthly Mileage Based Charges				
44 Cost per Mile per Month				

Block 7: Bid Documentation

45 Did you receive any bids in response to the Form 465 Request for Services posted on the RHCD website? ☐ Yes ☒ No
If you checked yes, copies of the bids **MUST** be mailed to RHCD.

Block 8: Certification

46 <input checked="" type="checkbox"/> I certify that the above named entity has considered all bids received and selected the most cost-effective method of providing the requested service or services. The "most cost-effective service" is defined in the Universal Service Order as the service available at the lowest cost after consideration of the features, quality of transmission, reliability, and other factors that the health care provider deems necessary for the service to adequately transmit the health care services required by the health care provider.	
47 <input checked="" type="checkbox"/> Pursuant to 47 C.F.R. Secs. 54.601 and 54.603, I certify that the HCP or consortium that I am representing satisfies all of the requirements herein and will abide by all of the relevant requirements, including all applicable FCC rules, with respect to universal service benefits provided under 47 U.S.C. Sec. 254. I understand that any letter from RHCD that erroneously states that funds will be made available for the benefit of the applicant may be subject to rescission.	
48 <input checked="" type="checkbox"/> I hereby certify that the billed entity will maintain complete billing records for the service for five years.	
49 <input checked="" type="checkbox"/> I certify that I am authorized to submit this request on behalf of the above-named Billed Entity and HCP, and that I have examined this form and attachments and that to the best of my knowledge, information, and belief, all statements of fact contained herein are true.	
50 Signature Electronically signed	51 Date 06-Dec-2013
52 Printed name of authorized person Richard B Wideman	53 Title or position of authorized person TeleHealth Coordinat
54 Employer of authorized person Norton Sound Health Corporation	55 Employer's FCC RN 0014835128

Please remember:

- ★ You must submit one Form 466 for **each service** (i.e., circuit) for which you request reduced rates. For example:
 - If you are requesting reduced rates for **two** T1 lines, you must submit **two** Forms 466.
 - If you are requesting reduced rates for **two** ISDN lines & **one** Frame Relay line, you must submit **three** Forms 466.
- ★ If the service described on this form is subject to the **28-day competitive bidding requirement**, do not select a carrier or complete the Form 466 before or during the 28-day posting period.
- ★ You must provide evidence of the urban rate if you have completed Block 6 and have not used the urban rates from the website.
- ★ This form, attachments, and supporting documents should be combined in one envelope and sent to the RHCD.
- ★ If the service described on this form changes (e.g., rate change) during the funding year, you must notify RHCD immediately and submit a revised Form 466.
- ★ If you have any questions, call RHCD at 1-800-229-5476.

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This form should be submitted to:
Rural Health Care Division
30 Lanidex Plaza West, P.O.Box 685
Parsippany NJ 07054-0685

Health Care Providers Universal Service Funding Request and Certification Form

The Deadline to submit this Form is the June 30th End of the Funding Year.

Estimated time per response: 3 hours

Read instructions thoroughly before completing this form. Failure to comply may cause delayed or denied funding.**Block 1: HCP Information**

1 HCP Name St Michael Clinic	2 HCP Number 10678
3 Form 465 Application # 43137996	4 Consortium Name (If any)

Block 2: Bill Payer Information

5 Billed Entity Name St. Michael Clinic	6 Billed Entity FCC RN 0014835128
7 Contact Name Richard B Wideman	
8 Address Line 1 94 Bald St	
9 Address Line 2	
10 City St Michael	11 State AK 12 Zip 99659
13 Contact Phone # (907) 443-3272	14 Fax # 15 E-Mail rwideman@nshcorp.org

Block 3: Funding Year Information

16 Funding Year - Check only one box
<input checked="" type="checkbox"/> Year 2013 (7/1/2013-6/30/2014) <input type="checkbox"/> Year 2014 (7/1/2014-6/30/2015) <input type="checkbox"/> Year 2015 (7/1/2015-6/30/2016)

Block 4: Service Information

17 Type of Service & Circuit Bandwidth (Enclose documentation.) Satellite Service 2 Mbps
18 Total Billed Miles 0 19 Maximum Allowable Distance (From Form 465) 426
20 Percentage of HCP's service used for the provision of health care. 100 (If less than 100%, please explain.) If the HCP indicated it is a part-time eligible entity (on Form 465), describe method of allocating prorated support.

Connection Information	Carrier A	Carrier B	Carrier C	Carrier D
21 Service Provider Name	GCI Communication Corp			
22 Service Provider Identification Number (SPIN)	143001199			
23 Service Provider Contact Person Name	Steve Walker			
24 Service Provider Contact Person's Phone #	(907) 865-6416			
25 Service Provider Contact Person Email	swalker@gci.com			
26 Circuit Start Location	94 Bald St St Michael, AK 99659			
27 Circuit Termination Location	1000 Greg Kruschek Ave Nome, AK 99762			
28 Billing Account Number	RH000220008			
29 Tariff, Contract or other document reference number	HC-302			
30 Date Contract Signed or Date HCP Selected Carrier	09-Aug-2010			
31 Contract Expiration Date (mm/dd/yyyy or NA if MTM)	08-Aug-2015			
32 Service Installation Date	26-Jun-2013			
33 Actual Rural Rate per Month (Enclose Documentation)	10181.00			
34 If you are a consortium member OR have multiple carriers, please attach a Circuit Diagram to show how the sites interconnect and which carrier(s) provides each circuit segment. Circuit Diagram included: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
35 Are you a mobile rural health care provider? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, see instructions and attach a list of all sites to be served.				

<p>IF YOU ARE REQUESTING SUPPORT FOR MILEAGE-BASED CHARGES, COMPLETE BLOCK 5 ONLY AND SKIP BLOCK 6. (PLEASE SEE INSTRUCTIONS). IF YOU ARE REQUESTING SUPPORT BASED ON URBAN/RURAL RATE COMPARISON, SKIP BLOCK 5 AND COMPLETE ONLY BLOCK 6. YOUR APPLICATION CANNOT BE PROCESSED IF BOTH BLOCKS ARE COMPLETED.</p>				
<p>Block 5: Mileage-based Charge Discount Request</p>				
<p>Complete this block if you are seeking support for mileage (distance-based) charges only. Do not enter any other charges in this block. You may need to ask your service provider representative to provide this information.</p>				
36 Billed Circuit Miles				
37 Monthly Mileage Charges (Exclude Channel Termination chgs, etc.)				
38 Cost per Mile per Month				
<p>If Line 33 equals Line 37, please ensure that ONLY mileage-related charges are included in Line 37. (See instructions.)</p>				
<p>Block 6: Comprehensive Rate Comparison Request</p>				
<p>Complete Block 6 if you have not completed Block 5 and are requesting support for all elements of your telecommunications service necessary for the provision of health care. The information in this block will establish the difference between the urban and rural rates for your requested service. Please call RHCD at 1-800-229-5476 if you need assistance.</p>				
39 One-time Urban Rate Charge (in selected large city)	0			
40 One-time Rural Rate Charge (in city where HCP is located)	0			
41 Monthly Urban Rate (in selected large city). From RHCD web site: <input type="checkbox"/> or Other rate documentation attached: <input checked="" type="checkbox"/>	140.00			
<p>If your circuit includes charges for mileage over the Maximum Allowable Dist., (Line 19), please complete Lines 42 to 44. Otherwise, skip to Block 7.</p>				
42 Billed Circuit Miles				
43 Monthly Mileage Based Charges				
44 Cost per Mile per Month				
<p>Block 7: Bid Documentation</p>				
<p>45 Did you receive any bids in response to the Form 465 Request for Services posted on the RHCD website? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>If you checked yes, copies of the bids MUST be mailed to RHCD.</p>				
<p>Block 8: Certification</p>				
<p>46 <input checked="" type="checkbox"/> I certify that the above named entity has considered all bids received and selected the most cost-effective method of providing the requested service or services. The "most cost-effective service" is defined in the Universal Service Order as the service available at the lowest cost after consideration of the features, quality of transmission, reliability, and other factors that the health care provider deems necessary for the service to adequately transmit the health care services required by the health care provider.</p>				
<p>47 <input checked="" type="checkbox"/> Pursuant to 47 C.F.R. Secs. 54.601 and 54.603, I certify that the HCP or consortium that I am representing satisfies all of the requirements herein and will abide by all of the relevant requirements, including all applicable FCC rules, with respect to universal service benefits provided under 47 U.S.C. Sec. 254. I understand that any letter from RHCD that erroneously states that funds will be made available for the benefit of the applicant may be subject to rescission.</p>				
<p>48 <input checked="" type="checkbox"/> I hereby certify that the billed entity will maintain complete billing records for the service for five years.</p>				
<p>49 <input checked="" type="checkbox"/> I certify that I am authorized to submit this request on behalf of the above-named Billed Entity and HCP, and that I have examined this form and attachments and that to the best of my knowledge, information, and belief, all statements of fact contained herein are true.</p>				
50 Signature Electronically signed		51 Date 06-Dec-2013		
52 Printed name of authorized person Richard B Wideman		53 Title or position of authorized person TeleHealth Coordinator		
54 Employer of authorized person Norton Sound Health Corporation		55 Employer's FCC RN 0014835128		

Please remember:

- ♦ You must submit one Form 466 for each service (i.e., circuit) for which you request reduced rates. For example:
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- ♦ If the service described on this form is subject to the 28-day competitive bidding requirement, do not select a carrier or complete the Form 466 before or during the 28-day posting period.
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This form should be submitted to:
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30 Lanidex Plaza West, P.O.Box 685
Parsippany NJ 07054-0685

Health Care Providers Universal Service
Funding Request and Certification Form

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Estimated time per response: 3 hours

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1 HCP Name Savoonga Clinic	2 HCP Number 10679
3 Form 465 Application # 43137997	4 Consortium Name (If any)

Block 2: Bill Payer Information

5 Billed Entity Name Savoonga Clinic	6 Billed Entity FCC RN 0014835128
7 Contact Name Richard B Wideman	
8 Address Line 1 3 Airport Way	
9 Address Line 2	
10 City Savoonga	11 State AK 12 Zip 99769
13 Contact Phone # (907) 443-3272	14 Fax # 15 E-Mail rwideman@nshcorp.org

Block 3: Funding Year Information

16 Funding Year - Check only one box		
<input checked="" type="checkbox"/> Year 2013 (7/1/2013-6/30/2014)	<input type="checkbox"/> Year 2014 (7/1/2014-6/30/2015)	<input type="checkbox"/> Year 2015 (7/1/2015-6/30/2016)

Block 4: Service Information

17 Type of Service & Circuit Bandwidth (Enclose documentation.) Satellite Service 2 Mbps	
18 Total Billed Miles 0	19 Maximum Allowable Distance (From Form 465) 684
20 Percentage of HCP's service used for the provision of health care. 100 (If less than 100%, please explain.) If the HCP indicated it is a part-time eligible entity (on Form 465), describe method of allocating prorated support. 	

Connection Information	Carrier A	Carrier B	Carrier C	Carrier D
21 Service Provider Name	GCI Communication Corp			
22 Service Provider Identification Number (SPIN)	143001199			
23 Service Provider Contact Person Name	Steve Walker			
24 Service Provider Contact Person's Phone #	(907) 868-6416			
25 Service Provider Contact Person Email	swalker@gci.com			
26 Circuit Start Location	3 Airport Way Savoonga, AK 99769			
27 Circuit Termination Location	1000 Greg Kruschek Ave Nome, AK 99762			
28 Billing Account Number	RH000220006			
29 Tariff, Contract or other document reference number	HC-302			
30 Date Contract Signed or Date HCP Selected Carrier	09-Aug-2010			
31 Contract Expiration Date (mm/dd/yyyy or NA if MTM)	08-Aug-2015			
32 Service Installation Date	01-Jul-2013			
33 Actual Rural Rate per Month (Enclose Documentation)	10524.84			
34 If you are a consortium member OR have multiple carriers, please attach a Circuit Diagram to show how the sites interconnect and which carrier(s) provides each circuit segment. Circuit Diagram included: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
35 Are you a mobile rural health care provider? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, see instructions and attach a list of all sites to be served.				

IF YOU ARE REQUESTING SUPPORT FOR MILEAGE-BASED CHARGES, COMPLETE BLOCK 5 ONLY AND SKIP BLOCK 6. (PLEASE SEE INSTRUCTIONS). IF YOU ARE REQUESTING SUPPORT BASED ON URBAN/RURAL RATE COMPARISON, SKIP BLOCK 5 AND COMPLETE ONLY BLOCK 6. YOUR APPLICATION CANNOT BE PROCESSED IF BOTH BLOCKS ARE COMPLETED.

Block 5: Mileage-based Charge Discount Request

Complete this block if you are seeking support for mileage (distance-based) charges only. Do not enter any other charges in this block. You may need to ask your service provider representative to provide this information.

36 Billed Circuit Miles				
37 Monthly Mileage Charges (Exclude Channel Termination chgs, etc.)				
38 Cost per Mile per Month				

If Line 33 equals Line 37, please ensure that ONLY mileage-related charges are included in Line 37. (See instructions.)

Block 6: Comprehensive Rate Comparison Request

Complete Block 6 if you have not completed Block 5 and are requesting support for all elements of your telecommunications service necessary for the provision of health care. The information in this block will establish the difference between the urban and rural rates for your requested service. Please call RHCD at 1-800-229-5476 if you need assistance.

39 One-time Urban Rate Charge (in selected large city)	0			
40 One-time Rural Rate Charge (in city where HCP is located)	0			
41 Monthly Urban Rate (in selected large city). From RHCD web site: <input type="checkbox"/> or Other rate documentation attached: <input checked="" type="checkbox"/>	140.00			

If your circuit includes charges for mileage over the Maximum Allowable Dist., (Line 19), please complete Lines 42 to 44. Otherwise, skip to Block 7.

42 Billed Circuit Miles				
43 Monthly Mileage Based Charges				
44 Cost per Mile per Month				

Block 7: Bid Documentation

45 Did you receive any bids in response to the Form 465 Request for Services posted on the RHCD website? ☐ Yes ☒ No
If you checked yes, copies of the bids MUST be mailed to RHCD.

Block 8: Certification

46 <input checked="" type="checkbox"/> I certify that the above named entity has considered all bids received and selected the most cost-effective method of providing the requested service or services. The "most cost-effective service" is defined in the Universal Service Order as the service available at the lowest cost after consideration of the features, quality of transmission, reliability, and other factors that the health care provider deems necessary for the service to adequately transmit the health care services required by the health care provider.	
47 <input checked="" type="checkbox"/> Pursuant to 47 C.F.R. Secs. 54.601 and 54.603, I certify that the HCP or consortium that I am representing satisfies all of the requirements herein and will abide by all of the relevant requirements, including all applicable FCC rules, with respect to universal service benefits provided under 47 U.S.C. Sec. 254. I understand that any letter from RHCD that erroneously states that funds will be made available for the benefit of the applicant may be subject to rescission.	
48 <input checked="" type="checkbox"/> I hereby certify that the billed entity will maintain complete billing records for the service for five years.	
49 <input checked="" type="checkbox"/> I certify that I am authorized to submit this request on behalf of the above-named Billed Entity and HCP, and that I have examined this form and attachments and that to the best of my knowledge, information, and belief, all statements of fact contained herein are true.	
50 Signature Electronically signed	51 Date 06-Dec-2013
52 Printed name of authorized person Richard B Wideman	53 Title or position of authorized person TeleHealth Coordin
54 Employer of authorized person Norton Sound Health Corporation	55 Employer's FCC RN 0014835128

Please remember:

- ♦ You must submit one Form 466 for **each service** (i.e., circuit) for which you request reduced rates. For example:
 - If you are requesting reduced rates for **two** T1 lines, you must submit **two** Forms 466.
 - If you are requesting reduced rates for **two** ISDN lines & **one** Frame Relay line, you must submit **three** Forms 466.
- ♦ **If the service described on this form is subject to the 28-day competitive bidding requirement, do not select a carrier or complete the Form 466 before or during the 28-day posting period.**
- ♦ **You must provide evidence of the urban rate if you have completed Block 6 and have not used the urban rates from the website.**
- ♦ This form, attachments, and supporting documents should be combined in one envelope and sent to the RHCD.
- ♦ If the service described on this form changes (e.g., rate change) during the funding year, **you must notify RHCD immediately** and submit a revised Form 466.
- ♦ If you have any questions, call RHCD at 1-800-229-5476.

Persons willfully making false statements on this form can be punished by fine or forfeiture under the Communications Act, 47 U.S.C. Secs. 502, 503(b), or fine or imprisonment under Title 18 of the United States Code, 18 U.S.C. Sec. 1001.

FCC NOTICE FOR INDIVIDUALS REQUIRED BY THE PRIVACY ACT AND THE PAPERWORK REDUCTION ACT

Part 3 of the Commission's Rules authorize the FCC to request the information on this form. The data reported will be used to ensure that health care providers have selected the most cost-effective method of providing the requested services as set forth in 47 C.F.R. § 54.603(b)(4). The information will be used by the Universal Service Administrative Company and/or the staff of the Federal Communications Commission, to evaluate this form, to provide information for enforcement and rulemaking proceedings and to maintain a current inventory of applicants, health care providers, billed entities, and service providers. No authorization can be granted unless all information requested is provided. Failure to provide all requested information will delay the processing of the application or result in the application being returned without action. Information requested by this form will be available for public inspection. Your response is required to obtain the requested authorization.

The public reporting for this collection of information is estimated to average 3 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the required data, and completing and reviewing the collection of information. If you have any comments on this burden estimate, or how we can improve the collection and reduce the burden it causes you, please write to the Federal Communications Commission, AMD-PER, Paperwork Reduction Act Project (3060-0804), Washington, DC 20554. We will also accept your comments regarding the Paperwork Reduction Act aspects of this collection via the Internet if you send them to pra@fcc.gov. PLEASE DO NOT SEND YOUR RESPONSE TO THIS ADDRESS.

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THE FOREGOING NOTICE IS REQUIRED BY THE PRIVACY ACT OF 1974, PUBLIC LAW 93-579, DECEMBER 31, 1974, 5 U.S.C. 552a(e)(3) AND THE PAPERWORK REDUCTION ACT OF 1995, PUBLIC LAW 104-13, OCTOBER 1, 1995, 44 U.S.C. SECTION 3507.

This form should be submitted to:
Rural Health Care Division
30 Lanidex Plaza West, P.O.Box 685
Parsippany NJ 07054-0685

SKK 2 Mbps

FCC Form

466

Health Care Providers Universal Service
Funding Request and Certification Form

Approval by OMB

3060-0804

The Deadline to submit this Form is the June 30th End of the Funding Year.

Estimated time per response: 3 hours

Read instructions thoroughly before completing this form. Failure to comply may cause delayed or denied funding.

Block 1: HCP Information

1 HCP Name Shaktolik Clinic	2 HCP Number 10680
3 Form 465 Application # 43137992	4 Consortium Name (If any)

Block 2: Bill Payer Information

5 Billed Entity Name Shaktolik Clinic	6 Billed Entity FCC RN 0014835128
7 Contact Name Richard B Wideman	
8 Address Line 1 9 Ocean Veiw Rd	
9 Address Line 2	
10 City Shaktolik	11 State AK 12 Zip 99771
13 Contact Phone # (907) 443-3272	14 Fax # 15 E-Mail rwideman@nshcorp.org

Block 3: Funding Year Information

16 Funding Year - Check only one box
<input checked="" type="checkbox"/> Year 2013 (7/1/2013-6/30/2014) <input type="checkbox"/> Year 2014 (7/1/2014-6/30/2015) <input type="checkbox"/> Year 2015 (7/1/2015-6/30/2016)

Block 4: Service Information

17 Type of Service & Circuit Bandwidth (Enclose documentation.) Satellite Service 2 Mbps
18 Total Billed Miles 0 19 Maximum Allowable Distance (From Form 465) 424
20 Percentage of HCP's service used for the provision of health care. 100 (If less than 100%, please explain.) If the HCP indicated it is a part-time eligible entity (on Form 465), describe method of allocating prorated support.

Connection Information	Carrier A	Carrier B	Carrier C	Carrier D
21 Service Provider Name	GCI Communication Corp			
22 Service Provider Identification Number (SPIN)	143001199			
23 Service Provider Contact Person Name	Steve Walker			
24 Service Provider Contact Person's Phone #	(907) 868-6416			
25 Service Provider Contact Person Email	swalker@gci.com			
26 Circuit Start Location	9 Ocean Veiw Rd Shaktolik, AK 99771			
27 Circuit Termination Location	1090 Greg Kruschek Ave Nome, AK 99762			
28 Billing Account Number	RHG00220008			
29 Tariff, Contract or other document reference number	HC-302			
30 Date Contract Signed or Date HCP Selected Carrier	09-Aug-2010			
31 Contract Expiration Date (mm/dd/yyyy or NA if MTM)	09-Aug-2015			
32 Service Installation Date	01-Jul-2013			
33 Actual Rural Rate per Month (Enclose Documentation)	10181 00			
34 If you are a consortium member OR have multiple carriers, please attach a Circuit Diagram to show how the sites interconnect and which carrier(s) provides each circuit segment. Circuit Diagram included: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
35 Are you a mobile rural health care provider? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, see instructions and attach a list of all sites to be served.				

FCC Form 466

November 2012

IF YOU ARE REQUESTING SUPPORT FOR MILEAGE-BASED CHARGES, COMPLETE BLOCK 5 ONLY AND SKIP BLOCK 6. (PLEASE SEE INSTRUCTIONS). IF YOU ARE REQUESTING SUPPORT BASED ON URBAN/RURAL RATE COMPARISON, SKIP BLOCK 5 AND COMPLETE ONLY BLOCK 6. YOUR APPLICATION CANNOT BE PROCESSED IF BOTH BLOCKS ARE COMPLETED.				
Block 5: Mileage-based Charge Discount Request				
Complete this block if you are seeking support for mileage (distance-based) charges only. Do not enter any other charges in this block. You may need to ask your service provider representative to provide this information.				
36 Billed Circuit Miles				
37 Monthly Mileage Charges (Exclude Channel Termination chgs, etc.)				
38 Cost per Mile per Month				
If Line 33 equals Line 37, please ensure that ONLY mileage-related charges are included in Line 37. (See instructions.)				
Block 6: Comprehensive Rate Comparison Request				
Complete Block 6 if you have not completed Block 5 and are requesting support for all elements of your telecommunications service necessary for the provision of health care. The information in this block will establish the difference between the urban and rural rates for your requested service. Please call RHCD at 1-800-229-5476 if you need assistance.				
39 One-time Urban Rate Charge (in selected large city)	0			
40 One-time Rural Rate Charge (in city where HCP is located)	0			
41 Monthly Urban Rate (in selected large city). From RHCD web site: <input type="checkbox"/> or Other rate documentation attached: <input checked="" type="checkbox"/>	140.00			
If your circuit includes charges for mileage over the Maximum Allowable Dist., (Line 19), please complete Lines 42 to 44. Otherwise, skip to Block 7.				
42 Billed Circuit Miles				
43 Monthly Mileage Based Charges				
44 Cost per Mile per Month				
Block 7: Bid Documentation				
45 Did you receive any bids in response to the Form 485 Request for Services posted on the RHCD website? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If you checked yes, copies of the bids MUST be mailed to RHCD.				
Block 8: Certification				
46 <input checked="" type="checkbox"/> I certify that the above named entity has considered all bids received and selected the most cost-effective method of providing the requested service or services. The "most cost-effective service" is defined in the Universal Service Order as the service available at the lowest cost after consideration of the features, quality of transmission, reliability, and other factors that the health care provider deems necessary for the service to adequately transmit the health care services required by the health care provider.				
47 <input checked="" type="checkbox"/> Pursuant to 47 C.F.R. Secs. 54.601 and 54.603, I certify that the HCP or consortium that I am representing satisfies all of the requirements herein and will abide by all of the relevant requirements, including all applicable FCC rules, with respect to universal service benefits provided under 47 U.S.C. Sec. 254. I understand that any letter from RHCD that erroneously states that funds will be made available for the benefit of the applicant may be subject to rescission.				
48 <input checked="" type="checkbox"/> I hereby certify that the billed entity will maintain complete billing records for the service for five years.				
49 <input checked="" type="checkbox"/> I certify that I am authorized to submit this request on behalf of the above-named Billed Entity and HCP, and that I have examined this form and attachments and that to the best of my knowledge, information, and belief, all statements of fact contained herein are true.				
50 Signature Electronically signed		51 Date 06-Dec-2013		
52 Printed name of authorized person Richard B Wideman		53 Title or position of authorized person TeleHealth Coordinating		
54 Employer of authorized person Norton Sound Health Corporation		55 Employer's FCC RN 0014835128		

Please remember:

- ♦ You must submit one Form 466 for **each service** (i.e., circuit) for which you request reduced rates. For example:
 - If you are requesting reduced rates for **two T1 lines**, you must submit **two** Forms 466.
 - If you are requesting reduced rates for **two ISDN lines & one Frame Relay line**, you must submit **three** Forms 466.
- ♦ **If the service described on this form is subject to the 28-day competitive bidding requirement, do not select a carrier or complete the Form 466 before or during the 28-day posting period.**
- ♦ **You must provide evidence of the urban rate if you have completed Block 6 and have not used the urban rates from the website.**
- ♦ This form, attachments, and supporting documents should be combined in one envelope and sent to the RHCD.
- ♦ If the service described on this form changes (e.g., rate change) during the funding year, **you must notify RHCD immediately** and submit a revised Form 466.
- ♦ If you have any questions, call RHCD at 1-800-229-5476.

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This form should be submitted to:
Rural Health Care Division
30 Lanidex Plaza West, P.O.Box 685
Parsippany NJ 07054-0685

Health Care Providers Universal Service Funding Request and Certification Form

The Deadline to submit this Form is the June 30th End of the Funding Year.

Estimated time per response: 3 hours

Read instructions thoroughly before completing this form. Failure to comply may cause delayed or denied funding.**Block 1: HCP Information**

1 HCP Name Katherine Miksruaq Olanna Health Clinic	2 HCP Number 10681
3 Form 465 Application # 43137999	4 Consortium Name (If any)

Block 2: Bill Payer Information

5 Billed Entity Name Shishmaref Clinic	6 Billed Entity FCC RN 0014835128
7 Contact Name Richard B Wideman	
8 Address Line 1 133 Lagoon View	
9 Address Line 2	
10 City Shishmaref	11 State AK 12 Zip 99772
13 Contact Phone # (907) 443-3272	14 Fax # 15 E-Mail rwideman@nshcorp.org

Block 3: Funding Year Information

16 Funding Year - Check only one box		
<input checked="" type="checkbox"/> Year 2013 (7/1/2013-6/30/2014)	<input type="checkbox"/> Year 2014 (7/1/2014-6/30/2015)	<input type="checkbox"/> Year 2015 (7/1/2015-6/30/2016)

Block 4: Service Information

17 Type of Service & Circuit Bandwidth (Enclose documentation.)	Satellite Service 2 Mbps
18 Total Billed Miles 0	19 Maximum Allowable Distance (From Form 465) 610
20 Percentage of HCP's service used for the provision of health care. 100 (If less than 100%, please explain.) If the HCP indicated it is a part-time eligible entity (on Form 465), describe method of allocating prorated support.	

Connection Information	Carrier A	Carrier B	Carrier C	Carrier D
21 Service Provider Name	GCI Communication Corp			
22 Service Provider Identification Number (SPIN)	143001199			
23 Service Provider Contact Person Name	Steve Walker			
24 Service Provider Contact Person's Phone #	(907) 868-6416			
25 Service Provider Contact Person Email	swalker@gci.com			
26 Circuit Start Location	133 Lagoon View Shishmaref, AK 99772			
27 Circuit Termination Location	1000 Greg Kruschek Ave Nome, AK 99762			
28 Billing Account Number	RH000220008			
29 Tariff, Contract or other document reference number	HC-302			
30 Date Contract Signed or Date HCP Selected Carrier	09-Aug-2010			
31 Contract Expiration Date (mm/dd/yyyy or NA if MTM)	08-Aug-2015			
32 Service Installation Date	01-Jul-2013			
33 Actual Rural Rate per Month (Enclose Documentation)	10181.00			
34 If you are a consortium member OR have multiple carriers, please attach a Circuit Diagram to show how the sites interconnect and which carrier(s) provides each circuit segment. Circuit Diagram included: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
35 Are you a mobile rural health care provider? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, see instructions and attach a list of all sites to be served.				

<p>IF YOU ARE REQUESTING SUPPORT FOR MILEAGE-BASED CHARGES, COMPLETE BLOCK 5 ONLY AND SKIP BLOCK 6. (PLEASE SEE INSTRUCTIONS). IF YOU ARE REQUESTING SUPPORT BASED ON URBAN/RURAL RATE COMPARISON, SKIP BLOCK 5 AND COMPLETE ONLY BLOCK 6. YOUR APPLICATION CANNOT BE PROCESSED IF BOTH BLOCKS ARE COMPLETED.</p>				
<p>Block 5: Mileage-based Charge Discount Request</p>				
<p>Complete this block if you are seeking support for mileage (distance-based) charges only. Do not enter any other charges in this block. You may need to ask your service provider representative to provide this information.</p>				
36 Billed Circuit Miles				
37 Monthly Mileage Charges (Exclude Channel Termination chgs, etc.)				
38 Cost per Mile per Month				
<p>If Line 33 equals Line 37, please ensure that ONLY mileage-related charges are included in Line 37. (See instructions.)</p>				
<p>Block 6: Comprehensive Rate Comparison Request</p>				
<p>Complete Block 6 if you have not completed Block 5 and are requesting support for all elements of your telecommunications service necessary for the provision of health care. The information in this block will establish the difference between the urban and rural rates for your requested service. Please call RHCD at 1-800-229-5476 if you need assistance.</p>				
39 One-time Urban Rate Charge (in selected large city)	0			
40 One-time Rural Rate Charge (in city where HCP is located)	0			
41 Monthly Urban Rate (in selected large city). From RHCD web site: <input type="checkbox"/> or Other rate documentation attached: <input checked="" type="checkbox"/>	140.00			
<p>If your circuit includes charges for mileage over the Maximum Allowable Dist., (Line 19), please complete Lines 42 to 44. Otherwise, skip to Block 7.</p>				
42 Billed Circuit Miles				
43 Monthly Mileage Based Charges				
44 Cost per Mile per Month				
<p>Block 7: Bid Documentation</p>				
<p>45 Did you receive any bids in response to the Form 465 Request for Services posted on the RHCD website? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>If you checked yes, copies of the bids MUST be mailed to RHCD.</p>				
<p>Block 8: Certification</p>				
<p>46 <input checked="" type="checkbox"/> I certify that the above named entity has considered all bids received and selected the most cost-effective method of providing the requested service or services. The "most cost-effective service" is defined in the Universal Service Order as the service available at the lowest cost after consideration of the features, quality of transmission, reliability, and other factors that the health care provider deems necessary for the service to adequately transmit the health care services required by the health care provider.</p>				
<p>47 <input checked="" type="checkbox"/> Pursuant to 47 C.F.R. Secs. 54.601 and 54.603, I certify that the HCP or consortium that I am representing satisfies all of the requirements herein and will abide by all of the relevant requirements, including all applicable FCC rules, with respect to universal service benefits provided under 47 U.S.C. Sec. 254. I understand that any letter from RHCD that erroneously states that funds will be made available for the benefit of the applicant may be subject to rescission.</p>				
<p>48 <input checked="" type="checkbox"/> I hereby certify that the billed entity will maintain complete billing records for the service for five years.</p>				
<p>49 <input checked="" type="checkbox"/> I certify that I am authorized to submit this request on behalf of the above-named Billed Entity and HCP, and that I have examined this form and attachments and that to the best of my knowledge, information, and belief, all statements of fact contained herein are true.</p>				
50 Signature Electronically signed		51 Date 06-Dec-2013		
52 Printed name of authorized person Richard B Wideman		53 Title or position of authorized person TeleHealth Coordinator		
54 Employer of authorized person Norton Sound Health Corporation		55 Employer's FCC RN 0014835128		

Please remember:

- You must submit one Form 466 for **each service** (i.e., circuit) for which you request reduced rates. For example:
 - If you are requesting reduced rates for **two** T1 lines, you must submit **two** Forms 466.
 - If you are requesting reduced rates for **two** ISDN lines & **one** Frame Relay line, you must submit **three** Forms 466.
- If the service described on this form is subject to the 28-day competitive bidding requirement, do not select a carrier or complete the Form 466 before or during the 28-day posting period.
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This form should be submitted to:
Rural Health Care Division
30 Lanidex Plaza West, P.O.Box 685
Parsippany NJ 07054-0685

WBB

FCC Form

466

Health Care Providers Universal Service Funding Request and Certification Form

Approval by OMB

3060-0804

The Deadline to submit this Form is the June 30th End of the Funding Year.

Estimated time per response: 3 hours

Read instructions thoroughly before completing this form. Failure to comply may cause delayed or denied funding.**Block 1: HCP Information**

1 HCP Name Stebbins Clinic	2 HCP Number 10682
3 Form 465 Application # 43138000	4 Consortium Name (If any)

Block 2: Bill Payer Information

5 Billed Entity Name Stebbins Clinic	6 Billed Entity FCC RN 0014835128
7 Contact Name Richard B Wideman	
8 Address Line 1 50 Carabou St	
9 Address Line 2	
10 City Stebbins	11 State AK 12 Zip 99671
13 Contact Phone # (907) 443-3272	14 Fax # 15 E-Mail rwideman@nshcorp.org

Block 3: Funding Year Information

16 Funding Year - Check only one box
<input checked="" type="checkbox"/> Year 2013 (7/1/2013-6/30/2014) <input type="checkbox"/> Year 2014 (7/1/2014-6/30/2015) <input type="checkbox"/> Year 2015 (7/1/2015-6/30/2016)

Block 4: Service Information

17 Type of Service & Circuit Bandwidth (Enclose documentation.) Satellite Service 2 Mbps
18 Total Billed Miles 0 19 Maximum Allowable Distance (From Form 465) 434
20 Percentage of HCP's service used for the provision of health care. 100 (If less than 100%, please explain.) If the HCP indicated it is a part-time eligible entity (on Form 465), describe method of allocating prorated support.

Connection Information	Carrier A	Carrier B	Carrier C	Carrier D
21 Service Provider Name	GCI Communication Corp			
22 Service Provider Identification Number (SPIN)	143001199			
23 Service Provider Contact Person Name	Steve Walker			
24 Service Provider Contact Person's Phone #	(907) 868-6416			
25 Service Provider Contact Person Email	swalker@gci.com			
26 Circuit Start Location	50 Carabou St Stebbins, AK 99671			
27 Circuit Termination Location	1000 Greg Kruschek Ave Nome, AK 99762			
28 Billing Account Number	RH000220008			
29 Tariff, Contract or other document reference number	HC-302			
30 Date Contract Signed or Date HCP Selected Carrier	09-Aug-2010			
31 Contract Expiration Date (mm/dd/yyyy or NA if MTM)	08-Aug-2015			
32 Service Installation Date	25-Jul-2013			
33 Actual Rural Rate per Month (Enclose Documentation)	10181 00			
34 If you are a consortium member OR have multiple carriers, please attach a Circuit Diagram to show how the sites interconnect and which carrier(s) provides each circuit segment. Circuit Diagram included: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
35 Are you a mobile rural health care provider? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, see instructions and attach a list of all sites to be served.				

FCC Form 466

November 2012

IF YOU ARE REQUESTING SUPPORT FOR MILEAGE-BASED CHARGES, COMPLETE BLOCK 5 ONLY AND SKIP BLOCK 6. (PLEASE SEE INSTRUCTIONS). IF YOU ARE REQUESTING SUPPORT BASED ON URBAN/RURAL RATE COMPARISON, SKIP BLOCK 5 AND COMPLETE ONLY BLOCK 6. YOUR APPLICATION CANNOT BE PROCESSED IF BOTH BLOCKS ARE COMPLETED.

Block 5: Mileage-based Charge Discount Request

Complete this block if you are seeking support for mileage (distance-based) charges only. Do not enter any other charges in this block. You may need to ask your service provider representative to provide this information.

36 Billed Circuit Miles				
37 Monthly Mileage Charges (Exclude Channel Termination chgs, etc.)				
38 Cost per Mile per Month				

If Line 33 equals Line 37, please ensure that **ONLY** mileage-related charges are included in Line 37. (See Instructions.)

Block 6: Comprehensive Rate Comparison Request

Complete Block 6 if you have not completed Block 5 and are requesting support for all elements of your telecommunications service necessary for the provision of health care. The information in this block will establish the difference between the urban and rural rates for your requested service.

Please call RHCD at 1-800-229-5476 if you need assistance.

39 One-time Urban Rate Charge (in selected large city)	0			
40 One-time Rural Rate Charge (in city where HCP is located)	0			
41 Monthly Urban Rate (in selected large city). From RHCD web site: <input type="checkbox"/> or Other rate documentation attached: <input checked="" type="checkbox"/>	140.00			

If your circuit includes charges for mileage over the Maximum Allowable Dist., (Line 19), please complete Lines 42 to 44. Otherwise, skip to Block 7.

42 Billed Circuit Miles				
43 Monthly Mileage Based Charges				
44 Cost per Mile per Month				

Block 7: Bid Documentation

45 Did you receive any bids in response to the Form 465 Request for Services posted on the RHCD website? ☐ Yes ☒ No

If you checked yes, copies of the bids **MUST** be mailed to RHCD.

Block 8: Certification

46 <input checked="" type="checkbox"/> I certify that the above named entity has considered all bids received and selected the most cost-effective method of providing the requested service or services. The "most cost-effective service" is defined in the Universal Service Order as the service available at the lowest cost after consideration of the features, quality of transmission, reliability, and other factors that the health care provider deems necessary for the service to adequately transmit the health care services required by the health care provider.	
47 <input checked="" type="checkbox"/> Pursuant to 47 C.F.R. Secs. 54.601 and 54.603, I certify that the HCP or consortium that I am representing satisfies all of the requirements herein and will abide by all of the relevant requirements, including all applicable FCC rules, with respect to universal service benefits provided under 47 U.S.C. Sec. 254. I understand that any letter from RHCD that erroneously states that funds will be made available for the benefit of the applicant may be subject to rescission.	
48 <input checked="" type="checkbox"/> I hereby certify that the billed entity will maintain complete billing records for the service for five years.	
49 <input checked="" type="checkbox"/> I certify that I am authorized to submit this request on behalf of the above-named Billed Entity and HCP, and that I have examined this form and attachments and that to the best of my knowledge, information, and belief, all statements of fact contained herein are true.	
50 Signature Electronically signed	51 Date 06-Dec-2013
52 Printed name of authorized person Richard B Wideman	53 Title or position of authorized person TeleHealth Coordinating
54 Employer of authorized person Norton Sound Health Corporation	55 Employer's FCC RN 0014835128

Please remember:

- You must submit one Form 466 for each service (i.e., circuit) for which you request reduced rates. For example:
 - If you are requesting reduced rates for two T1 lines, you must submit two Forms 466.
 - If you are requesting reduced rates for two ISDN lines & one Frame Relay line, you must submit three Forms 466.
- If the service described on this form is subject to the 28-day competitive bidding requirement, do not select a carrier or complete the Form 466 before or during the 28-day posting period.
- You must provide evidence of the urban rate if you have completed Block 6 and have not used the urban rates from the website.
- This form, attachments, and supporting documents should be combined in one envelope and sent to the RHCD.
- If the service described on this form changes (e.g., rate change) during the funding year, you must notify RHCD immediately and submit a revised Form 466.
- If you have any questions, call RHCD at 1-800-229-5476.

Persons willfully making false statements on this form can be punished by fine or forfeiture under the Communications Act, 47 U.S.C. Secs. 502, 503(b), or fine or imprisonment under Title 18 of the United States Code, 18 U.S.C. Sec. 1001.

FCC NOTICE FOR INDIVIDUALS REQUIRED BY THE PRIVACY ACT AND THE PAPERWORK REDUCTION ACT

Part 3 of the Commission's Rules authorize the FCC to request the information on this form. The data reported will be used to ensure that health care providers have selected the most cost-effective method of providing the requested services as set forth in 47 C.F.R. § 54.603(b)(4). The information will be used by the Universal Service Administrative Company and/or the staff of the Federal Communications Commission, to evaluate this form, to provide information for enforcement and rulemaking proceedings and to maintain a current inventory of applicants, health care providers, billed entities, and service providers. No authorization can be granted unless all information requested is provided. Failure to provide all requested information will delay the processing of the application or result in the application being returned without action. Information requested by this form will be available for public inspection. Your response is required to obtain the requested authorization.

The public reporting for this collection of information is estimated to average 3 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the required data, and completing and reviewing the collection of information. If you have any comments on this burden estimate, or how we can improve the collection and reduce the burden it causes you, please write to the Federal Communications Commission, AMD-PERF, Paperwork Reduction Act Project (3060-0804), Washington, DC 20554. We will also accept your comments regarding the Paperwork Reduction Act aspects of this collection via the Internet if you send them to pra@fcc.gov. PLEASE DO NOT SEND YOUR RESPONSE TO THIS ADDRESS.

Remember - You are not required to respond to a collection of information sponsored by the Federal government, and the government may not conduct or sponsor this collection, unless it displays a currently valid OMB control number or if we fail to provide you with this notice. This collection has been assigned an OMB control number of 3060-0804.

THE FOREGOING NOTICE IS REQUIRED BY THE PRIVACY ACT OF 1974, PUBLIC LAW 93-579, DECEMBER 31, 1974, 5 U.S.C. 552a(e)(3) AND THE PAPERWORK REDUCTION ACT OF 1995, PUBLIC LAW 104-13, OCTOBER 1, 1995, 44 U.S.C. SECTION 3507.

This form should be submitted to:
Rural Health Care Division
30 Lanidex Plaza West, P.O.Box 685
Parsippany NJ 07054-0685

THA

FCC Form

466

Health Care Providers Universal Service Funding Request and Certification Form

Approval by OMB

3060-0804

The Deadline to submit this Form is the June 30th End of the Funding Year.

Estimated time per response: 3 hours

Read instructions thoroughly before completing this form. Failure to comply may cause delayed or denied funding.**Block 1: HCP Information**

1 HCP Name Teller Clinic	2 HCP Number 10683
3 Form 465 Application # 43138003	4 Consortium Name (If any)

Block 2: Bill Payer Information

5 Billed Entity Name Teller Clinic	6 Billed Entity FCC RN 0014835128
7 Contact Name Richard B Wideman	
8 Address Line 1 545 Airport Ave	
9 Address Line 2	
10 City Teller	11 State AK 12 Zip 99778
13 Contact Phone # (907) 443-3272	14 Fax # 15 E-Mail rwideman@nshcorp.org

Block 3: Funding Year Information

16 Funding Year - Check only one box
<input checked="" type="checkbox"/> Year 2013 (7/1/2013-6/30/2014) <input type="checkbox"/> Year 2014 (7/1/2014-6/30/2015) <input type="checkbox"/> Year 2015 (7/1/2015-6/30/2016)

Block 4: Service Information

17 Type of Service & Circuit Bandwidth (Enclose documentation.) Satellite Service 2 Mbps
18 Total Billed Miles 0 19 Maximum Allowable Distance (From Form 465) 589
20 Percentage of HCP's service used for the provision of health care. 100 (If less than 100%, please explain.) If the HCP indicated it is a part-time eligible entity (on Form 465), describe method of allocating prorated support.

Connection Information	Carrier A	Carrier B	Carrier C	Carrier D
21 Service Provider Name	GCI Communication Corp			
22 Service Provider Identification Number (SPIN)	143001199			
23 Service Provider Contact Person Name	Steve Walker			
24 Service Provider Contact Person's Phone #	(907) 868-6416			
25 Service Provider Contact Person Email	swalker@gci.com			
26 Circuit Start Location	545 Airport Ave Teller, AK 99778			
27 Circuit Termination Location	1000 Greg Kruschek Ave Nome, AK 99762			
28 Billing Account Number	RH000220008			
29 Tariff, Contract or other document reference number	HC-302			
30 Date Contract Signed or Date HCP Selected Carrier	09-Aug-2010			
31 Contract Expiration Date (mm/dd/yyyy or NA if MTM)	08-Aug-2015			
32 Service Installation Date	24-Jul-2013			
33 Actual Rural Rate per Month (Enclose Documentation)	10181.00			
34 If you are a consortium member OR have multiple carriers, please attach a Circuit Diagram to show how the sites interconnect and which carrier(s) provides each circuit segment. Circuit Diagram included: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
35 Are you a mobile rural health care provider? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, see instructions and attach a list of all sites to be served.				

FCC Form 466

November 2012

IF YOU ARE REQUESTING SUPPORT FOR MILEAGE-BASED CHARGES, COMPLETE BLOCK 5 ONLY AND SKIP BLOCK 6. (PLEASE SEE INSTRUCTIONS). IF YOU ARE REQUESTING SUPPORT BASED ON URBAN/RURAL RATE COMPARISON, SKIP BLOCK 5 AND COMPLETE ONLY BLOCK 6. YOUR APPLICATION CANNOT BE PROCESSED IF BOTH BLOCKS ARE COMPLETED.

Block 5: Mileage-based Charge Discount Request

Complete this block if you are seeking support for mileage (distance-based) charges only. Do not enter any other charges in this block. You may need to ask your service provider representative to provide this information.

36 Billed Circuit Miles				
37 Monthly Mileage Charges (Exclude Channel Termination chgs, etc.)				
38 Cost per Mile per Month				

If Line 33 equals Line 37, please ensure that ONLY mileage-related charges are included in Line 37. (See instructions.)

Block 6: Comprehensive Rate Comparison Request

Complete Block 6 if you have not completed Block 5 and are requesting support for all elements of your telecommunications service necessary for the provision of health care. The information in this block will establish the difference between the urban and rural rates for your requested service. Please call RHCD at 1-800-229-5476 if you need assistance.

39 One-time Urban Rate Charge (in selected large city)	0			
40 One-time Rural Rate Charge (in city where HCP is located)	0			
41 Monthly Urban Rate (in selected large city). From RHCD web site: <input type="checkbox"/> or Other rate documentation attached: <input checked="" type="checkbox"/>	140.00			

If your circuit includes charges for mileage over the Maximum Allowable Dist., (Line 19), please complete Lines 42 to 44. Otherwise, skip to Block 7.

42 Billed Circuit Miles				
43 Monthly Mileage Based Charges				
44 Cost per Mile per Month				

Block 7: Bid Documentation

45 Did you receive any bids in response to the Form 465 Request for Services posted on the RHCD website? ☐ Yes ☒ No
If you checked yes, copies of the bids MUST be mailed to RHCD.

Block 8: Certification

46 <input checked="" type="checkbox"/> I certify that the above named entity has considered all bids received and selected the most cost-effective method of providing the requested service or services. The "most cost-effective service" is defined in the Universal Service Order as the service available at the lowest cost after consideration of the features, quality of transmission, reliability, and other factors that the health care provider deems necessary for the service to adequately transmit the health care services required by the health care provider.	
47 <input checked="" type="checkbox"/> Pursuant to 47 C.F.R. Secs. 54.601 and 54.603, I certify that the HCP or consortium that I am representing satisfies all of the requirements herein and will abide by all of the relevant requirements, including all applicable FCC rules, with respect to universal service benefits provided under 47 U.S.C. Sec. 254. I understand that any letter from RHCD that erroneously states that funds will be made available for the benefit of the applicant may be subject to rescission.	
48 <input checked="" type="checkbox"/> I hereby certify that the billed entity will maintain complete billing records for the service for five years.	
49 <input checked="" type="checkbox"/> I certify that I am authorized to submit this request on behalf of the above-named Billed Entity and HCP, and that I have examined this form and attachments and that to the best of my knowledge, information, and belief, all statements of fact contained herein are true.	
50 Signature Electronically signed	51 Date 06-Dec-2013
52 Printed name of authorized person Richard B Wideman	53 Title or position of authorized person TeleHealth Coordinator
54 Employer of authorized person Norton Sound Health Corporation	55 Employer's FCC RN 0014835128

Please remember:

- You must submit one Form 466 for **each service** (i.e., circuit) for which you request reduced rates. For example:
 - If you are requesting reduced rates for **two T1 lines**, you must submit **two** Forms 466.
 - If you are requesting reduced rates for **two ISDN lines & one Frame Relay line**, you must submit **three** Forms 466.
- If the service described on this form is subject to the 28-day competitive bidding requirement, do not select a carrier or complete the Form 466 before or during the 28-day posting period.
- You must provide evidence of the urban rate if you have completed Block 6 and have not used the urban rates from the website.
- This form, attachments, and supporting documents should be combined in one envelope and sent to the RHCD.
- If the service described on this form changes (e.g., rate change) during the funding year, you must notify RHCD immediately and submit a revised Form 466.
- If you have any questions, call RHCD at 1-800-229-5476.

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This form should be submitted to:
Rural Health Care Division
30 Lanidex Plaza West, P.O.Box 685
Parsippany NJ 07054-0685

Health Care Providers Universal Service
Funding Request and Certification Form

The Deadline to submit this Form is the June 30th End of the Funding Year.

Estimated time per response: 3 hours

Read instructions thoroughly before completing this form. Failure to comply may cause delayed or denied funding.**Block 1: HCP Information**

1 HCP Name Euksavik Clinic	2 HCP Number 10684
3 Form 465 Application # 43137995	4 Consortium Name (If any)

Block 2: Bill Payer Information

5 Billed Entity Name Euksavik Clinic	6 Billed Entity FCC RN 0014835128
7 Contact Name Ricard B Wideman	
8 Address Line 1 189 Airport Road	
9 Address Line 2	
10 City Unalakleet	11 State AK 12 Zip 99684
13 Contact Phone # (907) 443-3272	14 Fax # 15 E-Mail rwideman@nshcorp.org

Block 3: Funding Year Information

16 Funding Year - Check only one box			
<input checked="" type="checkbox"/> Year 2013 (7/1/2013-6/30/2014)	<input type="checkbox"/> Year 2014 (7/1/2014-6/30/2015)	<input type="checkbox"/> Year 2015 (7/1/2015-6/30/2016)	

Block 4: Service Information

17 Type of Service & Circuit Bandwidth (Enclose documentation.) Satellite Service 2 Mbps	
18 Total Billed Miles 0	19 Maximum Allowable Distance (From Form 465) 400
20 Percentage of HCP's service used for the provision of health care. 100 (If less than 100%, please explain.) If the HCP indicated it is a part-time eligible entity (on Form 465), describe method of allocating prorated support. 	

Connection Information	Carrier A	Carrier B	Carrier C	Carrier D
21 Service Provider Name	GCI Communication Corp			
22 Service Provider Identification Number (SPIN)	143001199			
23 Service Provider Contact Person Name	Steve Walker			
24 Service Provider Contact Person's Phone #	(907) 868-6416			
25 Service Provider Contact Person Email	swalker@gci.com			
26 Circuit Start Location	189 Airport Road Unalakleet, AK 99684			
27 Circuit Termination Location	1000 Greg Kruschek Ave Nome, AK 99762			
28 Billing Account Number	RH000220008			
29 Tariff, Contract or other document reference number	HC-302			
30 Date Contract Signed or Date HCP Selected Carrier	09-Aug-2010			
31 Contract Expiration Date (mm/dd/yyyy or NA if MTM)	08-Aug-2015			
32 Service Installation Date	19-Jul-2013			
33 Actual Rural Rate per Month (Enclose Documentation)	10524.64			
34 If you are a consortium member OR have multiple carriers, please attach a Circuit Diagram to show how the sites interconnect and which carrier(s) provides each circuit segment. Circuit Diagram included: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
35 Are you a mobile rural health care provider? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, see instructions and attach a list of all sites to be served.				

<p>IF YOU ARE REQUESTING SUPPORT FOR MILEAGE-BASED CHARGES, COMPLETE BLOCK 5 ONLY AND SKIP BLOCK 6. (PLEASE SEE INSTRUCTIONS). IF YOU ARE REQUESTING SUPPORT BASED ON URBAN/RURAL RATE COMPARISON, SKIP BLOCK 5 AND COMPLETE ONLY BLOCK 6. YOUR APPLICATION CANNOT BE PROCESSED IF BOTH BLOCKS ARE COMPLETED.</p>				
<p>Block 5: Mileage-based Charge Discount Request</p>				
<p>Complete this block if you are seeking support for mileage (distance-based) charges only. Do not enter any other charges in this block. You may need to ask your service provider representative to provide this information.</p>				
36 Billed Circuit Miles				
37 Monthly Mileage Charges (Exclude Channel Termination chgs, etc.)				
38 Cost per Mile per Month				
<p>If Line 33 equals Line 37, please ensure that ONLY mileage-related charges are included in Line 37. (See instructions.)</p>				
<p>Block 6: Comprehensive Rate Comparison Request</p>				
<p>Complete Block 6 if you have not completed Block 5 and are requesting support for all elements of your telecommunications service necessary for the provision of health care. The information in this block will establish the difference between the urban and rural rates for your requested service. Please call RHCD at 1-800-229-5476 if you need assistance.</p>				
39 One-time Urban Rate Charge (in selected large city)	0			
40 One-time Rural Rate Charge (in city where HCP is located)	0			
41 Monthly Urban Rate (in selected large city). From RHCD web site: <input type="checkbox"/> or Other rate documentation attached: <input checked="" type="checkbox"/>	140.00			
<p>If your circuit includes charges for mileage over the Maximum Allowable Dist., (Line 19), please complete Lines 42 to 44. Otherwise, skip to Block 7.</p>				
42 Billed Circuit Miles				
43 Monthly Mileage Based Charges				
44 Cost per Mile per Month				
<p>Block 7: Bid Documentation</p>				
<p>45 Did you receive any bids in response to the Form 465 Request for Services posted on the RHCD website? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If you checked yes, copies of the bids MUST be mailed to RHCD.</p>				
<p>Block 8: Certification</p>				
<p>46 <input checked="" type="checkbox"/> I certify that the above named entity has considered all bids received and selected the most cost-effective method of providing the requested service or services. The "most cost-effective service" is defined in the Universal Service Order as the service available at the lowest cost after consideration of the features, quality of transmission, reliability, and other factors that the health care provider deems necessary for the service to adequately transmit the health care services required by the health care provider.</p>				
<p>47 <input checked="" type="checkbox"/> Pursuant to 47 C.F.R. Secs. 54.601 and 54.603, I certify that the HCP or consortium that I am representing satisfies all of the requirements herein and will abide by all of the relevant requirements, including all applicable FCC rules, with respect to universal service benefits provided under 47 U.S.C. Sec. 254. I understand that any letter from RHCD that erroneously states that funds will be made available for the benefit of the applicant may be subject to rescission.</p>				
<p>48 <input checked="" type="checkbox"/> I hereby certify that the billed entity will maintain complete billing records for the service for five years.</p>				
<p>49 <input checked="" type="checkbox"/> I certify that I am authorized to submit this request on behalf of the above-named Billed Entity and HCP, and that I have examined this form and attachments and that to the best of my knowledge, information, and belief, all statements of fact contained herein are true.</p>				
50 Signature Electronically signed		51 Date 06-Dec-2013		
52 Printed name of authorized person Richard B Wideman		53 Title or position of authorized person TeleHealth Coordina		
54 Employer of authorized person Norton Sound Health Corporation		55 Employer's FCC RN 0014835128		

Please remember:

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This form should be submitted to:
Rural Health Care Division
30 Lanidex Plaza West, P.O.Box 685
Parsippany NJ 07054-0685

WPA

FCC Form

466

Health Care Providers Universal Service Funding Request and Certification Form

Approval by OMB

3060-0804

The Deadline to submit this Form is the June 30th End of the Funding Year.

Estimated time per response: 3 hours

Read instructions thoroughly before completing this form. Failure to comply may cause delayed or denied funding.**Block 1: HCP Information**

1 HCP Name Wales Clinic	2 HCP Number 10685
3 Form 466 Application # 43137990	4 Consortium Name (if any)

Block 2: Bill Payer Information

5 Billed Entity Name Wales Clinic	6 Billed Entity FCC RN 0014835128
7 Contact Name Richard B Wideman	
8 Address Line 1 530 Snowbank St	
9 Address Line 2	
10 City Wales	11 State AK 12 Zip 99783
13 Contact Phone # (907) 443-3272	14 Fax # 15 E-Mail rwideman@nshcorp.org

Block 3: Funding Year Information

16 Funding Year - Check only one box
<input checked="" type="checkbox"/> Year 2013 (7/1/2013-6/30/2014) <input type="checkbox"/> Year 2014 (7/1/2014-6/30/2015) <input type="checkbox"/> Year 2015 (7/1/2015-6/30/2016)

Block 4: Service Information

17 Type of Service & Circuit Bandwidth (Enclose documentation.) Satellite Service 2 Mbps
18 Total Billed Miles 0 19 Maximum Allowable Distance (From Form 465) 645
20 Percentage of HCP's service used for the provision of health care. 100 (If less than 100%, please explain.) If the HCP indicated it is a part-time eligible entity (on Form 465), describe method of allocating prorated support.

Connection Information	Carrier A	Carrier B	Carrier C	Carrier D
21 Service Provider Name	GCI Communication Corp			
22 Service Provider Identification Number (SPIN)	143001199			
23 Service Provider Contact Person Name	Steve Walker			
24 Service Provider Contact Person's Phone #	(907) 868-6416			
25 Service Provider Contact Person Email	swalker@gci.com			
26 Circuit Start Location	538 Snowbank St Wales, AK 99783			
27 Circuit Termination Location	1000 Greg Kruschek Ave Nome, AK 99762			
28 Billing Account Number	RH000220008			
29 Tariff, Contract or other document reference number	HC-302			
30 Date Contract Signed or Date HCP Selected Carrier	09-Aug-2010			
31 Contract Expiration Date (mm/dd/yyyy or NA if MTM)	08-Aug-2015			
32 Service Installation Date	01-Jul-2013			
33 Actual Rural Rate per Month (Enclose Documentation)	10181.00			
34 If you are a consortium member OR have multiple carriers, please attach a Circuit Diagram to show how the sites interconnect and which carrier(s) provides each circuit segment. Circuit Diagram included: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
35 Are you a mobile rural health care provider? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, see instructions and attach a list of all sites to be served.				

FCC Form 466

November 2012

IF YOU ARE REQUESTING SUPPORT FOR MILEAGE-BASED CHARGES, COMPLETE BLOCK 5 ONLY AND SKIP BLOCK 6. (PLEASE SEE INSTRUCTIONS). IF YOU ARE REQUESTING SUPPORT BASED ON URBAN/RURAL RATE COMPARISON, SKIP BLOCK 5 AND COMPLETE ONLY BLOCK 6. YOUR APPLICATION CANNOT BE PROCESSED IF BOTH BLOCKS ARE COMPLETED.

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39 One-time Urban Rate Charge (in selected large city)	0			
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41 Monthly Urban Rate (in selected large city). From RHCD web site: <input type="checkbox"/> or Other rate documentation attached: <input checked="" type="checkbox"/>	140.00			

If your circuit includes charges for mileage over the Maximum Allowable Dist., (Line 19), please complete Lines 42 to 44. Otherwise, skip to Block 7.

42 Billed Circuit Miles				
43 Monthly Mileage Based Charges				
44 Cost per Mile per Month				

Block 7: Bid Documentation

45 Did you receive any bids in response to the Form 465 Request for Services posted on the RHCD website? ☐ Yes ☒ No
If you checked yes, copies of the bids MUST be mailed to RHCD.

Block 8: Certification

46 <input checked="" type="checkbox"/> I certify that the above named entity has considered all bids received and selected the most cost-effective method of providing the requested service or services. The "most cost-effective service" is defined in the Universal Service Order as the service available at the lowest cost after consideration of the features, quality of transmission, reliability, and other factors that the health care provider deems necessary for the service to adequately transmit the health care services required by the health care provider.	
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50 Signature Electronically signed	51 Date 06-Dec-2013
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54 Employer of authorized person Norton Sound Health Corporation	55 Employer's FCC RN 0014835128

Please remember:

- ♦ You must submit one Form 466 for **each service** (i.e., circuit) for which you request reduced rates. For example:
 - If you are requesting reduced rates for **two** T1 lines, you must submit **two** Forms 466.
 - If you are requesting reduced rates for **two** ISDN lines & **one** Frame Relay line, you must submit **three** Forms 466.
- ♦ If the service described on this form is subject to the 28-day competitive bidding requirement, do not select a carrier or complete the Form 466 before or during the 28-day posting period.
- ♦ You must provide evidence of the urban rate if you have completed Block 6 and have not used the urban rates from the website.
- ♦ This form, attachments, and supporting documents should be combined in one envelope and sent to the RHCD.
- ♦ If the service described on this form changes (e.g., rate change) during the funding year, you must notify RHCD immediately and submit a revised Form 466.
- ♦ If you have any questions, call RHCD at 1-800-229-5476.

Persons willfully making false statements on this form can be punished by fine or forfeiture under the Communications Act, 47 U.S.C. Secs. 502, 503(b), or fine or imprisonment under Title 18 of the United States Code, 18 U.S.C. Sec. 1001.

FCC NOTICE FOR INDIVIDUALS REQUIRED BY THE PRIVACY ACT AND THE PAPERWORK REDUCTION ACT

Part 3 of the Commission's Rules authorize the FCC to request the information on this form. The data reported will be used to ensure that health care providers have selected the most cost-effective method of providing the requested services as set forth in 47 C.F.R. § 54.603(b)(4). The information will be used by the Universal Service Administrative Company and/or the staff of the Federal Communications Commission, to evaluate this form, to provide information for enforcement and rulemaking proceedings and to maintain a current inventory of applicants, health care providers, billed entities, and service providers. No authorization can be granted unless all information requested is provided. Failure to provide all requested information will delay the processing of the application or result in the application being returned without action. Information requested by this form will be available for public inspection. Your response is required to obtain the requested authorization.

The public reporting for this collection of information is estimated to average 3 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the required data, and completing and reviewing the collection of information. If you have any comments on this burden estimate, or how we can improve the collection and reduce the burden it causes you, please write to the Federal Communications Commission, AMD-PERM, Paperwork Reduction Act Project (3060-0804), Washington, DC 20554. We will also accept your comments regarding the Paperwork Reduction Act aspects of this collection via the Internet if you send them to pra@fcc.gov. PLEASE DO NOT SEND YOUR RESPONSE TO THIS ADDRESS.

Remember - You are not required to respond to a collection of information sponsored by the Federal government, and the government may not conduct or sponsor this collection, unless it displays a currently valid OMB control number or if we fail to provide you with this notice. This collection has been assigned an OMB control number of 3060-0804.

THE FOREGOING NOTICE IS REQUIRED BY THE PRIVACY ACT OF 1974, PUBLIC LAW 93-579, DECEMBER 31, 1974, 5 U.S.C. 552a(e)(3) AND THE PAPERWORK REDUCTION ACT OF 1995, PUBLIC LAW 104-13, OCTOBER 1, 1995, 44 U.S.C. SECTION 3507.

This form should be submitted to:
Rural Health Care Division
30 Lanidex Plaza West, P.O.Box 685
Parsippany NJ 07054-0685

FCC Form
466

Health Care Providers Universal Service
Funding Request and Certification Form

Approval by OMB
3060-0804

The Deadline to submit this Form is the June 30th End of the Funding Year.

Estimated time per response: 3 hours

Read instructions thoroughly before completing this form. Failure to comply may cause delayed or denied funding.

Block 1: HCP Information

1 HCP Name White Mountain Clinic	2 HCP Number 10686
3 Form 465 Application # 43137994	4 Consortium Name (If any)

Block 2: Bill Payer Information

5 Billed Entity Name White Mountain Clinic	6 Billed Entity FCC RN 0014835128
7 Contact Name Richard B Wideman	
8 Address Line 1 2 Scow John Rd	
9 Address Line 2	
10 City White Mountain	11 State AK 12 Zip 99784
13 Contact Phone # (907) 433-3272	14 Fax # 15 E-Mail rwideman@nshcorp.org

Block 3: Funding Year Information

16 Funding Year - Check only one box
☒ Year 2013 (7/1/2013-6/30/2014)
 ☐ Year 2014 (7/1/2014-6/30/2015)
 ☐ Year 2015 (7/1/2015-6/30/2016)

Block 4: Service Information

17 Type of Service & Circuit Bandwidth (Enclose documentation.) Satellite Service 2 Mbps

18 Total Billed Miles 0 19 Maximum Allowable Distance (From Form 465) 493

20 Percentage of HCP's service used for the provision of health care. 100 (If less than 100%, please explain.)
 If the HCP indicated it is a part-time eligible entity (on Form 465), describe method of allocating prorated support.

Connection Information	Carrier A	Carrier B	Carrier C	Carrier D
21 Service Provider Name	GCI Communication Corp			
22 Service Provider Identification Number (SPIN)	143001199			
23 Service Provider Contact Person Name	Steve Walker			
24 Service Provider Contact Person's Phone #	(907) 868-6416			
25 Service Provider Contact Person Email	swalker@gci.com			
26 Circuit Start Location	2 Scow John Rd Wales, AK 99784			
27 Circuit Termination Location	1000 Greg Kruschek Ave Nome, AK 99762			
28 Billing Account Number	RH000220008			
29 Tariff, Contract or other document reference number	HC-302			
30 Date Contract Signed or Date HCP Selected Carrier	09-Aug-2010			
31 Contract Expiration Date (mm/dd/yyyy or NA if MTM)	08-Aug-2015			
32 Service Installation Date	01-Jul-2013			
33 Actual Rural Rate per Month (Enclose Documentation)	10181.00			
34 If you are a consortium member OR have multiple carriers, please attach a Circuit Diagram to show how the sites interconnect and which carrier(s) provides each circuit segment. Circuit Diagram included: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
35 Are you a mobile rural health care provider? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, see instructions and attach a list of all sites to be served.				

IF YOU ARE REQUESTING SUPPORT FOR MILEAGE-BASED CHARGES, COMPLETE BLOCK 5 ONLY AND SKIP BLOCK 6. (PLEASE SEE INSTRUCTIONS). IF YOU ARE REQUESTING SUPPORT BASED ON URBAN/RURAL RATE COMPARISON, SKIP BLOCK 5 AND COMPLETE ONLY BLOCK 6. YOUR APPLICATION CANNOT BE PROCESSED IF BOTH BLOCKS ARE COMPLETED.				
Block 5: Mileage-based Charge Discount Request				
Complete this block if you are seeking support for mileage (distance-based) charges only. Do not enter any other charges in this block. You may need to ask your service provider representative to provide this information.				
36 Billed Circuit Miles				
37 Monthly Mileage Charges (Exclude Channel Termination chgs, etc.)				
38 Cost per Mile per Month				
If Line 33 equals Line 37, please ensure that ONLY mileage-related charges are included in Line 37. (See instructions.)				
Block 6: Comprehensive Rate Comparison Request				
Complete Block 6 if you have not completed Block 5 and are requesting support for all elements of your telecommunications service necessary for the provision of health care. The information in this block will establish the difference between the urban and rural rates for your requested service. Please call RHCD at 1-800-229-5476 if you need assistance.				
39 One-time Urban Rate Charge (in selected large city)	0			
40 One-time Rural Rate Charge (in city where HCP is located)	0			
41 Monthly Urban Rate (in selected large city). From RHCD web site: <input type="checkbox"/> or Other rate documentation attached: <input checked="" type="checkbox"/>	140.00			
If your circuit includes charges for mileage over the Maximum Allowable Dist., (Line 19), please complete Lines 42 to 44. Otherwise, skip to Block 7.				
42 Billed Circuit Miles				
43 Monthly Mileage Based Charges				
44 Cost per Mile per Month				
Block 7: Bid Documentation				
45 Did you receive any bids in response to the Form 465 Request for Services posted on the RHCD website? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If you checked yes, copies of the bids MUST be mailed to RHCD.				
Block 8: Certification				
46 <input checked="" type="checkbox"/> I certify that the above named entity has considered all bids received and selected the most cost-effective method of providing the requested service or services. The "most cost-effective service" is defined in the Universal Service Order as the service available at the lowest cost after consideration of the features, quality of transmission, reliability, and other factors that the health care provider deems necessary for the service to adequately transmit the health care services required by the health care provider.				
47 <input checked="" type="checkbox"/> Pursuant to 47 C.F.R. Secs. 54.601 and 54.603, I certify that the HCP or consortium that I am representing satisfies all of the requirements herein and will abide by all of the relevant requirements, including all applicable FCC rules, with respect to universal service benefits provided under 47 U.S.C. Sec. 254. I understand that any letter from RHCD that erroneously states that funds will be made available for the benefit of the applicant may be subject to rescission.				
48 <input checked="" type="checkbox"/> I hereby certify that the billed entity will maintain complete billing records for the service for five years.				
49 <input checked="" type="checkbox"/> I certify that I am authorized to submit this request on behalf of the above-named Billed Entity and HCP, and that I have examined this form and attachments and that to the best of my knowledge, information, and belief, all statements of fact contained herein are true.				
50 Signature Electronically signed		51 Date 06-Dec-2013		
52 Printed name of authorized person Richard B Wideman		53 Title or position of authorized person TeleHealth Coordinator		
54 Employer of authorized person Norton Sound Health Corporation		55 Employer's FCC RN 0014835128		

Please remember:

- ♦ You must submit one Form 466 for **each service** (i.e., circuit) for which you request reduced rates. For example:
 - If you are requesting reduced rates for **two T1 lines**, you must submit **two** Forms 466.
 - If you are requesting reduced rates for **two ISDN lines & one Frame Relay line**, you must submit **three** Forms 466.
- ♦ If the service described on this form is subject to the 28-day competitive bidding requirement, do not select a carrier or complete the Form 466 before or during the 28-day posting period.
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This form should be submitted to:
Rural Health Care Division
30 Lanidex Plaza West, P.O.Box 685
Parsippany NJ 07054-0685

ATTACHMENT 5

From: rhcadmin@usac.org [mailto:rhcadmin@usac.org]
Sent: Wednesday, August 13, 2014 8:34 AM
To: Richard Wideman
Subject: Funding Commitment Letter (FCL) for HCP 10673, FRN 13358841

Date: 13-Aug-2014

Funding Year: 2013
Health Care Provider (HCP) Name: Brevig Mission Clinic
HCP Number: 10673
FCC Form 465 Application Number: 43137988
Funding Request Number: 13358841

The Rural Health Care (RHC) division of the Universal Service Administrative Company (USAC) has completed the review of the *Funding Request and Certification Form (FCC Form 466)* submitted on behalf of the Health Care Provider (HCP) named above. Based on the information provided, RHC has determined that the HCP is eligible for the estimated support listed below. Additionally, if the HCP submitted a contract or service agreement with the form, the outcome of the contract review is included in this letter.

HCP Physical Location: 4311 Clarence Rd., Brevig Mission, AK, 99785

Service Type: Satellite Service

Bandwidth: 2 Mbps

Service Provider Name: GCI Communication Corp

Service Provider Identification Number (SPIN): 143001199

Billing Account Number: RH000220008

Funding Start Date	Funding End Date	Months of Support	Non-Recurring Support Amount	Monthly Recurring Support Amount	Total Support Amount	Contract Expiration Date
09-Oct-2013	30-Jun-2014	8.74194	\$0.00	\$10,041.00	\$87,777.82	08-Aug-2015

Note that the funding end date will coincide with the contract expiration date. Therefore, if the contract ends during this funding year, the HCP must participate in competitive bidding before selecting a new service provider (or continuing formerly contracted services on a month-to-month basis, or purchasing a term extension) to be eligible for funding for the entirety of the funding year.

It is the HCP's responsibility to review and verify that all information on this Funding Commitment Letter (FCL) is accurate. All account holders and the service provider listed on the form have received this FCL, and it is saved in the *My Documents* section of *My Portal*.

Contract/Service Agreement Endorsement Determination: Non-Evergreen/MTM

Non-evergreen (or month-to-month) service offering: If an HCP submits a service agreement that is not signed and dated, or if the type of service, the term, or location of service(s) are not specified, the service agreement will be designated as Non-evergreen, (month-to-month, tariffed service). The HCP must participate in competitive bidding (submit an FCC Form 465 and select the most cost-effective service and service provider) each funding year.

If, at any time, the funded services are not provided to the HCP, or the HCP is not otherwise receiving the approved funding, the HCP must notify RHC immediately.

The Billing Account Number, certifications, and all other information provided on FCC Forms 465, 466, 466-A, and 467 may be subject to audit by RHC and the FCC.¹ HCPs are subject to audits and other reviews that the RHC and/or the FCC may undertake to ensure that the universal service support is used in compliance with FCC program rules. If the funded service(s) are not used in compliance with program rules, program participants will be subject to enforcement activities and other means of recourse by RHC and other appropriate federal, state, and local authorities.

Next Steps:

Submit an FCC Form 467 (*Connection Certification*), which confirms receipt of the services for which funding has been approved, and the date on which the service provider began providing those services. Funding cannot be issued until this form is processed. To submit the FCC Form 467, go to the *My Forms* tab of *My Portal* and find the applicable Form 466 or Form 466-A and click on the "Create 467" button. Once the Form 467 is approved, the HCP and the service provider will receive a copy of the HCP Support Schedule (HSS). Receipt of the HSS means that the service provider must begin crediting the HCP for the funding amount (if it has not yet done so) and may begin to invoice USAC.

Appeals:

Appeals must be electronically date-stamped or postmarked within 60 days of the date of this letter. Letters of appeal must contain the HCP Number, Funding Request Number(s), the SPIN, the affected funding year, and documentation of the decision being appealed (this FCL, denial letter, etc.).

Additionally, FCC rule section 54.721 requires "a statement setting forth the party's interest in the matter presented for review; a full statement of relevant, material facts with supporting affidavits and documentation; the question presented for review...[and] a statement of the relief sought and the relevant statutory or regulatory provision pursuant to which such relief is sought."

Failure to include the required information in the letter of appeal or the required documentation to support the appeal may impact the appeal decision.

Detailed instructions on filing an appeal are found at: www.usac.org/rhc/about/program-integrity/appeals.aspx.

Details about and definitions of all terms used in this FCL are provided on the RHC website (www.usac.org/rhc).

For questions assistance, contact the RHC Help Desk at 1-800-229-5476, or rhc-admin@usac.org.

¹ 47 C.F.R. 54.619(c).

From: rhcadmin@usac.org [mailto:rhcadmin@usac.org]
Sent: Wednesday, August 06, 2014 9:43 AM
To: Richard Wideman
Subject: Funding Commitment Letter (FCL) for HCP 10674, FRN 13360511

Date: 06-Aug-2014

Funding Year: 2013
Health Care Provider (HCP) Name: Elim Clinic
HCP Number: 10674
FCC Form 465 Application Number: 43138001
Funding Request Number: 13360511

The Rural Health Care (RHC) division of the Universal Service Administrative Company (USAC) has completed the review of the *Funding Request and Certification Form (FCC Form 466)* submitted on behalf of the Health Care Provider (HCP) named above. Based on the information provided, RHC has determined that the HCP is eligible for the estimated support listed below. Additionally, if the HCP submitted a contract or service agreement with the form, the outcome of the contract review is included in this letter.

HCP Physical Location: 69 Old Airport Rd., Elim, AK, 99739
Service Type: Satellite Service
Bandwidth: 2 Mbps
Service Provider Name: GCI Communication Corp
Service Provider Identification Number (SPIN): 143001199
Billing Account Number: RH000220008

Funding Start Date	Funding End Date	Months of Support	Non-Recurring Support Amount	Monthly Recurring Support Amount	Total Support Amount	Contract Expiration Date
11-Oct-2013	30-Jun-2014	8.67742	\$0.00	\$10,041.00	\$87,129.97	08-Aug-2015

Note that the funding end date will coincide with the contract expiration date. Therefore, if the contract ends during this funding year, the HCP must participate in competitive bidding before selecting a new service provider (or continuing formerly contracted services on a month-to-month basis, or purchasing a term extension) to be eligible for funding for the entirety of the funding year.

It is the HCP's responsibility to review and verify that all information on this Funding Commitment Letter (FCL) is accurate. All account holders and the service provider listed on the form have received this FCL, and it is saved in the *My Documents* section of *My Portal*.

Contract/Service Agreement Endorsement Determination: Non-Evergreen/MTM

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If, at any time, the funded services are not provided to the HCP, or the HCP is not otherwise receiving the approved funding, the HCP must notify RHC immediately.

The Billing Account Number, certifications, and all other information provided on FCC Forms 465, 466, 466-A, and 467 may be subject to audit by RHC and the FCC.¹ HCPs are subject to audits and other reviews that the RHC and/or the FCC may undertake to ensure that the universal service support is used in compliance with FCC program rules. If the funded service(s) are not used in compliance with program rules, program participants will be subject to enforcement activities and other means of recourse by RHC and other appropriate federal, state, and local authorities.

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Appeals:

Appeals must be electronically date-stamped or postmarked within 60 days of the date of this letter. Letters of appeal must contain the HCP Number, Funding Request Number(s), the SPIN, the affected funding year, and documentation of the decision being appealed (this FCL, denial letter, etc.).

Additionally, FCC rule section 54.721 requires "a statement setting forth the party's interest in the matter presented for review; a full statement of relevant, material facts with supporting affidavits and documentation; the question presented for review...[and] a statement of the relief sought and the relevant statutory or regulatory provision pursuant to which such relief is sought."

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Details about and definitions of all terms used in this FCL are provided on the RHC website (www.usac.org/rhc).

For questions assistance, contact the RHC Help Desk at 1-800-229-5476, or rhc-admin@usac.org.

¹ 47 C.F.R. 54.619(c).

From: rhcadmin@usac.org [mailto:rhcadmin@usac.org]
Sent: Wednesday, August 06, 2014 9:25 AM
To: Richard Wideman
Subject: Funding Commitment Letter (FCL) for HCP 10675, FRN 13366771

Date: 06-Aug-2014

Funding Year: 2013
Health Care Provider (HCP) Name: Gambell Clinic
HCP Number: 10675
FCC Form 465 Application Number: 43137998
Funding Request Number: 13366771

The Rural Health Care (RHC) division of the Universal Service Administrative Company (USAC) has completed the review of the *Funding Request and Certification Form (FCC Form 466)* submitted on behalf of the Health Care Provider (HCP) named above. Based on the information provided, RHC has determined that the HCP is eligible for the estimated support listed below. Additionally, if the HCP submitted a contract or service agreement with the form, the outcome of the contract review is included in this letter.

HCP Physical Location: 190 Clinic Rd., Gambell, AK, 99742
Service Type: Satellite Service
Bandwidth: 2 Mbps
Service Provider Name: GCI Communication Corp
Service Provider Identification Number (SPIN): 143001199
Billing Account Number: RH000220008

Funding Start Date	Funding End Date	Months of Support	Non-Recurring Support Amount	Monthly Recurring Support Amount	Total Support Amount	Contract Expiration Date
11-Oct-2013	30-Jun-2014	8.67742	\$0.00	\$10,384.64	\$90,111.88	08-Aug-2015

Note that the funding end date will coincide with the contract expiration date. Therefore, if the contract ends during this funding year, the HCP must participate in competitive bidding before selecting a new service provider (or continuing formerly contracted services on a month-to-month basis, or purchasing a term extension) to be eligible for funding for the entirety of the funding year.

It is the HCP's responsibility to review and verify that all information on this Funding Commitment Letter (FCL) is accurate. All account holders and the service provider listed on the form have received this FCL, and it is saved in the *My Documents* section of *My Portal*.

Contract/Service Agreement Endorsement Determination: Non-Evergreen/MTM

Non-evergreen (or month-to-month) service offering: If an HCP submits a service agreement that is not signed and dated, or if the type of service, the term, or location of service(s) are not specified, the service agreement will be designated as Non-evergreen, (month-to-month, tariffed service). The HCP must participate in competitive bidding (submit an FCC Form 465 and select the most cost-effective service and service provider) each funding year.

If, at any time, the funded services are not provided to the HCP, or the HCP is not otherwise receiving the approved funding, the HCP must notify RHC immediately.

The Billing Account Number, certifications, and all other information provided on FCC Forms 465, 466, 466-A, and 467 may be subject to audit by RHC and the FCC.¹ HCPs are subject to audits and other reviews that the RHC and/or the FCC may undertake to ensure that the universal service support is used in compliance with FCC program rules. If the funded service(s) are not used in compliance with program rules, program participants will be subject to enforcement activities and other means of recourse by RHC and other appropriate federal, state, and local authorities.

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Appeals:

Appeals must be electronically date-stamped or postmarked within 60 days of the date of this letter. Letters of appeal must contain the HCP Number, Funding Request Number(s), the SPIN, the affected funding year, and documentation of the decision being appealed (this FCL, denial letter, etc.).

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For questions assistance, contact the RHC Help Desk at 1-800-229-5476, or rhc-admin@usac.org.

¹ 47 C.F.R. 54.619(c).

From: rhcadmin@usac.org [mailto:rhcadmin@usac.org]
Sent: Wednesday, July 30, 2014 9:11 AM
To: Richard Wideman
Subject: Funding Commitment Letter (FCL) for HCP 10676, FRN 13366781

Date: 30-Jul-2014

Funding Year: 2013
Health Care Provider (HCP) Name: Golovin Clinic
HCP Number: 10676
FCC Form 465 Application Number: 43137991
Funding Request Number: 13366781

The Rural Health Care (RHC) division of the Universal Service Administrative Company (USAC) has completed the review of the *Funding Request and Certification Form (FCC Form 466)* submitted on behalf of the Health Care Provider (HCP) named above. Based on the information provided, RHC has determined that the HCP is eligible for the estimated support listed below. Additionally, if the HCP submitted a contract or service agreement with the form, the outcome of the contract review is included in this letter.

HCP Physical Location: 39 Punguk St., Golovin, AK, 99762
Service Type: Satellite Service
Bandwidth: 2 Mbps
Service Provider Name: GCI Communication Corp
Service Provider Identification Number (SPIN): 143001199
Billing Account Number: RH000220008

Funding Start Date	Funding End Date	Months of Support	Non-Recurring Support Amount	Monthly Recurring Support Amount	Total Support Amount	Contract Expiration Date
09-Oct-2013	30-Jun-2014	8.74194	\$0.00	\$10,041.00	\$87,777.82	08-Aug-2015

Note that the funding end date will coincide with the contract expiration date. Therefore, if the contract ends during this funding year, the HCP must participate in competitive bidding before selecting a new service provider (or continuing formerly contracted services on a month-to-month basis, or purchasing a term extension) to be eligible for funding for the entirety of the funding year.

It is the HCP's responsibility to review and verify that all information on this Funding Commitment Letter (FCL) is accurate. All account holders and the service provider listed on the form have received this FCL, and it is saved in the *My Documents* section of *My Portal*.

Contract/Service Agreement Endorsement Determination: Non-Evergreen/MTM

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The Billing Account Number, certifications, and all other information provided on FCC Forms 465, 466, 466-A, and 467 may be subject to audit by RHC and the FCC.¹ HCPs are subject to audits and other reviews that the RHC and/or the FCC may undertake to ensure that the universal service support is used in compliance with FCC program rules. If the funded service(s) are not used in compliance with program rules, program participants will be subject to enforcement activities and other means of recourse by RHC and other appropriate federal, state, and local authorities.

Next Steps:

Submit an FCC Form 467 (*Connection Certification*), which confirms receipt of the services for which funding has been approved, and the date on which the service provider began providing those services. Funding cannot be issued until this form is processed. To submit the FCC Form 467, go to the *My Forms* tab of *My Portal* and find the applicable Form 466 or Form 466-A and click on the "Create 467" button. Once the Form 467 is approved, the HCP and the service provider will receive a copy of the HCP Support Schedule (HSS). Receipt of the HSS means that the service provider must begin crediting the HCP for the funding amount (if it has not yet done so) and may begin to invoice USAC.

Appeals:

Appeals must be electronically date-stamped or postmarked within 60 days of the date of this letter. Letters of appeal must contain the HCP Number, Funding Request Number(s), the SPIN, the affected funding year, and documentation of the decision being appealed (this FCL, denial letter, etc.).

Additionally, FCC rule section 54.721 requires "a statement setting forth the party's interest in the matter presented for review; a full statement of relevant, material facts with supporting affidavits and documentation; the question presented for review...[and] a statement of the relief sought and the relevant statutory or regulatory provision pursuant to which such relief is sought."

Failure to include the required information in the letter of appeal or the required documentation to support the appeal may impact the appeal decision.

Detailed instructions on filing an appeal are found at: www.usac.org/rhc/about/program-integrity/appeals.aspx.

Details about and definitions of all terms used in this FCL are provided on the RHC website (www.usac.org/rhc).

For questions assistance, contact the RHC Help Desk at 1-800-229-5476, or rhc-admin@usac.org.

¹ 47 C.F.R. 54.619(c).

From: rhcadmin@usac.org [mailto:rhcadmin@usac.org]
Sent: Wednesday, July 23, 2014 1:52 PM
To: Richard Wideman
Subject: Funding Commitment Letter (FCL) for HCP 10677, FRN 13366801

Date: 23-Jul-2014

Funding Year: 2013
Health Care Provider (HCP) Name: Koyuk Clinic
HCP Number: 10677
FCC Form 465 Application Number: 43137993
Funding Request Number: 13366801

The Rural Health Care (RHC) division of the Universal Service Administrative Company (USAC) has completed the review of the *Funding Request and Certification Form (FCC Form 466)* submitted on behalf of the Health Care Provider (HCP) named above. Based on the information provided, RHC has determined that the HCP is eligible for the estimated support listed below. Additionally, if the HCP submitted a contract or service agreement with the form, the outcome of the contract review is included in this letter.

HCP Physical Location: 70 Poplar St., Koyuk, AK, 99753
Service Type: Satellite Service
Bandwidth: 2 Mbps
Service Provider Name: GCI Communication Corp
Service Provider Identification Number (SPIN): 143001199
Billing Account Number: RH000220008

Funding Start Date	Funding End Date	Months of Support	Non-Recurring Support Amount	Monthly Recurring Support Amount	Total Support Amount	Contract Expiration Date
09-Oct-2013	30-Jun-2014	8.74194	\$0.00	\$10,041.00	\$87,777.82	08-Aug-2015

Note that the funding end date will coincide with the contract expiration date. Therefore, if the contract ends during this funding year, the HCP must participate in competitive bidding before selecting a new service provider (or continuing formerly contracted services on a month-to-month basis, or purchasing a term extension) to be eligible for funding for the entirety of the funding year.

It is the HCP's responsibility to review and verify that all information on this Funding Commitment Letter (FCL) is accurate. All account holders and the service provider listed on the form have received this FCL, and it is saved in the *My Documents* section of *My Portal*.

Contract/Service Agreement Endorsement Determination: Non-Evergreen/MTM

Non-evergreen (or month-to-month) service offering: If an HCP submits a service agreement that is not signed and dated, or if the type of service, the term, or location of service(s) are not specified, the service agreement will be designated as Non-evergreen, (month-to-month, tariffed service). The HCP must participate in competitive bidding (submit an FCC Form 465 and select the most cost-effective service and service provider) each funding year.

If, at any time, the funded services are not provided to the HCP, or the HCP is not otherwise receiving the approved funding, the HCP must notify RHC immediately.

The Billing Account Number, certifications, and all other information provided on FCC Forms 465, 466, 466-A, and 467 may be subject to audit by RHC and the FCC.¹ HCPs are subject to audits and other reviews that the RHC and/or the FCC may undertake to ensure that the universal service support is used in compliance with FCC program rules. If the funded service(s) are not used in compliance with program rules, program participants will be subject to enforcement activities and other means of recourse by RHC and other appropriate federal, state, and local authorities.

Next Steps:

Submit an FCC Form 467 (*Connection Certification*), which confirms receipt of the services for which funding has been approved, and the date on which the service provider began providing those services. Funding cannot be issued until this form is processed. To submit the FCC Form 467, go to the *My Forms* tab of *My Portal* and find the applicable Form 466 or Form 466-A and click on the "Create 467" button. Once the Form 467 is approved, the HCP and the service provider will receive a copy of the HCP Support Schedule (HSS). Receipt of the HSS means that the service provider must begin crediting the HCP for the funding amount (if it has not yet done so) and may begin to invoice USAC.

Appeals:

Appeals must be electronically date-stamped or postmarked within 60 days of the date of this letter. Letters of appeal must contain the HCP Number, Funding Request Number(s), the SPIN, the affected funding year, and documentation of the decision being appealed (this FCL, denial letter, etc.).

Additionally, FCC rule section 54.721 requires "a statement setting forth the party's interest in the matter presented for review; a full statement of relevant, material facts with supporting affidavits and documentation; the question presented for review...[and] a statement of the relief sought and the relevant statutory or regulatory provision pursuant to which such relief is sought."

Failure to include the required information in the letter of appeal or the required documentation to support the appeal may impact the appeal decision.

Detailed instructions on filing an appeal are found at: www.usac.org/rhc/about/program-integrity/appeals.aspx.

Details about and definitions of all terms used in this FCL are provided on the RHC website (www.usac.org/rhc).

For questions assistance, contact the RHC Help Desk at 1-800-229-5476, or rhc-admin@usac.org.

¹ 47 C.F.R. 54.619(c).

From: rhcadmin@usac.org [mailto:rhcadmin@usac.org]
Sent: Wednesday, July 23, 2014 1:27 PM
To: Richard Wideman
Subject: Funding Commitment Letter (FCL) for HCP 10678, FRN 13366811

Date: 23-Jul-2014

Funding Year: 2013
Health Care Provider (HCP) Name: St Michael Clinic
HCP Number: 10678
FCC Form 465 Application Number: 43137996
Funding Request Number: 13366811

The Rural Health Care (RHC) division of the Universal Service Administrative Company (USAC) has completed the review of the *Funding Request and Certification Form (FCC Form 466)* submitted on behalf of the Health Care Provider (HCP) named above. Based on the information provided, RHC has determined that the HCP is eligible for the estimated support listed below. Additionally, if the HCP submitted a contract or service agreement with the form, the outcome of the contract review is included in this letter.

HCP Physical Location: 94 Bald St., St Michael, AK, 99659
Service Type: Satellite Service
Bandwidth: 2 Mbps
Service Provider Name: GCI Communication Corp
Service Provider Identification Number (SPIN): 143001199
Billing Account Number: RH000220008

Funding Start Date	Funding End Date	Months of Support	Non-Recurring Support Amount	Monthly Recurring Support Amount	Total Support Amount	Contract Expiration Date
11-Oct-2013	30-Jun-2014	8.67742	\$0.00	\$10,041.00	\$87,129.97	08-Aug-2015

Note that the funding end date will coincide with the contract expiration date. Therefore, if the contract ends during this funding year, the HCP must participate in competitive bidding before selecting a new service provider (or continuing formerly contracted services on a month-to-month basis, or purchasing a term extension) to be eligible for funding for the entirety of the funding year.

It is the HCP's responsibility to review and verify that all information on this Funding Commitment Letter (FCL) is accurate. All account holders and the service provider listed on the form have received this FCL, and it is saved in the *My Documents* section of *My Portal*.

Contract/Service Agreement Endorsement Determination: Non-Evergreen/MTM

Non-evergreen (or month-to-month) service offering: If an HCP submits a service agreement that is not signed and dated, or if the type of service, the term, or location of service(s) are not specified, the service agreement will be designated as Non-evergreen, (month-to-month, tariffed service). The HCP must participate in competitive bidding (submit an FCC Form 465 and select the most cost-effective service and service provider) each funding year.

If, at any time, the funded services are not provided to the HCP, or the HCP is not otherwise receiving the approved funding, the HCP must notify RHC immediately.

The Billing Account Number, certifications, and all other information provided on FCC Forms 465, 466, 466-A, and 467 may be subject to audit by RHC and the FCC.¹ HCPs are subject to audits and other reviews that the RHC and/or the FCC may undertake to ensure that the universal service support is used in compliance with FCC program rules. If the funded service(s) are not used in compliance with program rules, program participants will be subject to enforcement activities and other means of recourse by RHC and other appropriate federal, state, and local authorities.

Next Steps:

Submit an FCC Form 467 (*Connection Certification*), which confirms receipt of the services for which funding has been approved, and the date on which the service provider began providing those services. Funding cannot be issued until this form is processed. To submit the FCC Form 467, go to the *My Forms* tab of *My Portal* and find the applicable Form 466 or Form 466-A and click on the "Create 467" button. Once the Form 467 is approved, the HCP and the service provider will receive a copy of the HCP Support Schedule (HSS). Receipt of the HSS means that the service provider must begin crediting the HCP for the funding amount (if it has not yet done so) and may begin to invoice USAC.

Appeals:

Appeals must be electronically date-stamped or postmarked within 60 days of the date of this letter. Letters of appeal must contain the HCP Number, Funding Request Number(s), the SPIN, the affected funding year, and documentation of the decision being appealed (this FCL, denial letter, etc.).

Additionally, FCC rule section 54.721 requires "a statement setting forth the party's interest in the matter presented for review; a full statement of relevant, material facts with supporting affidavits and documentation; the question presented for review...[and] a statement of the relief sought and the relevant statutory or regulatory provision pursuant to which such relief is sought."

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Details about and definitions of all terms used in this FCL are provided on the RHC website (www.usac.org/rhc).

For questions assistance, contact the RHC Help Desk at 1-800-229-5476, or rhc-admin@usac.org.

¹ 47 C.F.R. 54.619(c).

From: rhcadmin@usac.org [mailto:rhcadmin@usac.org]
Sent: Wednesday, July 30, 2014 9:19 AM
To: Richard Wideman
Subject: Funding Commitment Letter (FCL) for HCP 10679, FRN 13366861

Date: 30-Jul-2014

Funding Year: 2013
Health Care Provider (HCP) Name: Savoonga Clinic
HCP Number: 10679
FCC Form 465 Application Number: 43137997
Funding Request Number: 13366861

The Rural Health Care (RHC) division of the Universal Service Administrative Company (USAC) has completed the review of the *Funding Request and Certification Form (FCC Form 466)* submitted on behalf of the Health Care Provider (HCP) named above. Based on the information provided, RHC has determined that the HCP is eligible for the estimated support listed below. Additionally, if the HCP submitted a contract or service agreement with the form, the outcome of the contract review is included in this letter.

HCP Physical Location: 3 Airport Way, Savoonga, AK, 99769
Service Type: Satellite Service
Bandwidth: 2 Mbps
Service Provider Name: GCI Communication Corp
Service Provider Identification Number (SPIN): 143001199
Billing Account Number: RH000220008

Funding Start Date	Funding End Date	Months of Support	Non-Recurring Support Amount	Monthly Recurring Support Amount	Total Support Amount	Contract Expiration Date
11-Oct-2013	30-Jun-2014	8.67742	\$0.00	\$10,384.64	\$90,111.88	08-Aug-2015

Note that the funding end date will coincide with the contract expiration date. Therefore, if the contract ends during this funding year, the HCP must participate in competitive bidding before selecting a new service provider (or continuing formerly contracted services on a month-to-month basis, or purchasing a term extension) to be eligible for funding for the entirety of the funding year.

It is the HCP's responsibility to review and verify that all information on this Funding Commitment Letter (FCL) is accurate. All account holders and the service provider listed on the form have received this FCL, and it is saved in the *My Documents* section of *My Portal*.

Contract/Service Agreement Endorsement Determination: Non-Evergreen/MTM

Non-evergreen (or month-to-month) service offering: If an HCP submits a service agreement that is not signed and dated, or if the type of service, the term, or location of service(s) are not specified, the service agreement will be designated as Non-evergreen, (month-to-month, tariffed service). The HCP must participate in competitive bidding (submit an FCC Form 465 and select the most cost-effective service and service provider) each funding year.

If, at any time, the funded services are not provided to the HCP, or the HCP is not otherwise receiving the approved funding, the HCP must notify RHC immediately.

The Billing Account Number, certifications, and all other information provided on FCC Forms 465, 466, 466-A, and 467 may be subject to audit by RHC and the FCC.¹ HCPs are subject to audits and other reviews that the RHC and/or the FCC may undertake to ensure that the universal service support is used in compliance with FCC program rules. If the funded service(s) are not used in compliance with program rules, program participants will be subject to enforcement activities and other means of recourse by RHC and other appropriate federal, state, and local authorities.

Next Steps:

Submit an FCC Form 467 (*Connection Certification*), which confirms receipt of the services for which funding has been approved, and the date on which the service provider began providing those services. Funding cannot be issued until this form is processed. To submit the FCC Form 467, go to the *My Forms* tab of *My Portal* and find the applicable Form 466 or Form 466-A and click on the "Create 467" button. Once the Form 467 is approved, the HCP and the service provider will receive a copy of the HCP Support Schedule (HSS). Receipt of the HSS means that the service provider must begin crediting the HCP for the funding amount (if it has not yet done so) and may begin to invoice USAC.

Appeals:

Appeals must be electronically date-stamped or postmarked within 60 days of the date of this letter. Letters of appeal must contain the HCP Number, Funding Request Number(s), the SPIN, the affected funding year, and documentation of the decision being appealed (this FCL, denial letter, etc.).

Additionally, FCC rule section 54.721 requires "a statement setting forth the party's interest in the matter presented for review; a full statement of relevant, material facts with supporting affidavits and documentation; the question presented for review...[and] a statement of the relief sought and the relevant statutory or regulatory provision pursuant to which such relief is sought."

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Details about and definitions of all terms used in this FCL are provided on the RHC website (www.usac.org/rhc).

For questions assistance, contact the RHC Help Desk at 1-800-229-5476, or rhc-admin@usac.org.

¹ 47 C.F.R. 54.619(c).

From: rhcadmin@usac.org [mailto:rhcadmin@usac.org]
Sent: Wednesday, July 23, 2014 1:38 PM
To: Richard Wideman
Subject: Funding Commitment Letter (FCL) for HCP 10680, FRN 13366881

Date: 23-Jul-2014

Funding Year: 2013
Health Care Provider (HCP) Name: Shaktoolik Clinic
HCP Number: 10680
FCC Form 465 Application Number: 43137992
Funding Request Number: 13366881

The Rural Health Care (RHC) division of the Universal Service Administrative Company (USAC) has completed the review of the *Funding Request and Certification Form (FCC Form 466)* submitted on behalf of the Health Care Provider (HCP) named above. Based on the information provided, RHC has determined that the HCP is eligible for the estimated support listed below. Additionally, if the HCP submitted a contract or service agreement with the form, the outcome of the contract review is included in this letter.

HCP Physical Location: 9 Ocean View Rd., Shaktoolik, AK, 99771
Service Type: Satellite Service
Bandwidth: 2 Mbps
Service Provider Name: GCI Communication Corp
Service Provider Identification Number (SPIN): 143001199
Billing Account Number: RH000220008

Funding Start Date	Funding End Date	Months of Support	Non-Recurring Support Amount	Monthly Recurring Support Amount	Total Support Amount	Contract Expiration Date
09-Oct-2013	30-Jun-2014	8.74194	\$0.00	\$10,041.00	\$87,777.82	08-Aug-2015

Note that the funding end date will coincide with the contract expiration date. Therefore, if the contract ends during this funding year, the HCP must participate in competitive bidding before selecting a new service provider (or continuing formerly contracted services on a month-to-month basis, or purchasing a term extension) to be eligible for funding for the entirety of the funding year.

It is the HCP's responsibility to review and verify that all information on this Funding Commitment Letter (FCL) is accurate. All account holders and the service provider listed on the form have received this FCL, and it is saved in the *My Documents* section of *My Portal*.

Contract/Service Agreement Endorsement Determination: Non-Evergreen/MTM

Non-evergreen (or month-to-month) service offering: If an HCP submits a service agreement that is not signed and dated, or if the type of service, the term, or location of service(s) are not specified, the service agreement will be designated as Non-evergreen, (month-to-month, tariffed service). The HCP must participate in competitive bidding (submit an FCC Form 465 and select the most cost-effective service and service provider) each funding year.

If, at any time, the funded services are not provided to the HCP, or the HCP is not otherwise receiving the approved funding, the HCP must notify RHC immediately.

The Billing Account Number, certifications, and all other information provided on FCC Forms 465, 466, 466-A, and 467 may be subject to audit by RHC and the FCC.¹ HCPs are subject to audits and other reviews that the RHC and/or the FCC may undertake to ensure that the universal service support is used in compliance with FCC program rules. If the funded service(s) are not used in compliance with program rules, program participants will be subject to enforcement activities and other means of recourse by RHC and other appropriate federal, state, and local authorities.

Next Steps:

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Appeals:

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Additionally, FCC rule section 54.721 requires "a statement setting forth the party's interest in the matter presented for review; a full statement of relevant, material facts with supporting affidavits and documentation; the question presented for review...[and] a statement of the relief sought and the relevant statutory or regulatory provision pursuant to which such relief is sought."

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Details about and definitions of all terms used in this FCL are provided on the RHC website (www.usac.org/rhc).

For questions assistance, contact the RHC Help Desk at 1-800-229-5476, or rhc-admin@usac.org.

¹ 47 C.F.R. 54.619(c).

From: rhcadmin@usac.org [mailto:rhcadmin@usac.org]
Sent: Wednesday, July 30, 2014 9:12 AM
To: Richard Wideman
Subject: Funding Commitment Letter (FCL) for HCP 10681, FRN 13366891

Date: 30-Jul-2014

Funding Year: 2013
Health Care Provider (HCP) Name: Katherine Miksruaq Olanna Health Clinic
HCP Number: 10681
FCC Form 465 Application Number: 43137999
Funding Request Number: 13366891

The Rural Health Care (RHC) division of the Universal Service Administrative Company (USAC) has completed the review of the *Funding Request and Certification Form (FCC Form 466)* submitted on behalf of the Health Care Provider (HCP) named above. Based on the information provided, RHC has determined that the HCP is eligible for the estimated support listed below. Additionally, if the HCP submitted a contract or service agreement with the form, the outcome of the contract review is included in this letter.

HCP Physical Location: 133 Lagoon View, Shishmaref, AK, 99772
Service Type: Satellite Service
Bandwidth: 2 Mbps
Service Provider Name: GCI Communication Corp
Service Provider Identification Number (SPIN): 143001199
Billing Account Number: RH000220008

Funding Start Date	Funding End Date	Months of Support	Non-Recurring Support Amount	Monthly Recurring Support Amount	Total Support Amount	Contract Expiration Date
11-Oct-2013	30-Jun-2014	8.67742	\$0.00	\$10,041.00	\$87,129.97	08-Aug-2015

Note that the funding end date will coincide with the contract expiration date. Therefore, if the contract ends during this funding year, the HCP must participate in competitive bidding before selecting a new service provider (or continuing formerly contracted services on a month-to-month basis, or purchasing a term extension) to be eligible for funding for the entirety of the funding year.

It is the HCP's responsibility to review and verify that all information on this Funding Commitment Letter (FCL) is accurate. All account holders and the service provider listed on the form have received this FCL, and it is saved in the *My Documents* section of *My Portal*.

Contract/Service Agreement Endorsement Determination: Non-Evergreen/MTM

Non-evergreen (or month-to-month) service offering: If an HCP submits a service agreement that is not signed and dated, or if the type of service, the term, or location of service(s) are not specified, the service agreement will be designated as Non-evergreen, (month-to-month, tariffed service). The HCP must participate in competitive bidding (submit an FCC Form 465 and select the most cost-effective service and service provider) each funding year.

If, at any time, the funded services are not provided to the HCP, or the HCP is not otherwise receiving the approved funding, the HCP must notify RHC immediately.

The Billing Account Number, certifications, and all other information provided on FCC Forms 465, 466, 466-A, and 467 may be subject to audit by RHC and the FCC.¹ HCPs are subject to audits and other reviews that the RHC and/or the FCC may undertake to ensure that the universal service support is used in compliance with FCC program rules. If the funded service(s) are not used in compliance with program rules, program participants will be subject to enforcement activities and other means of recourse by RHC and other appropriate federal, state, and local authorities.

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Appeals:

Appeals must be electronically date-stamped or postmarked within 60 days of the date of this letter. Letters of appeal must contain the HCP Number, Funding Request Number(s), the SPIN, the affected funding year, and documentation of the decision being appealed (this FCL, denial letter, etc.).

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Details about and definitions of all terms used in this FCL are provided on the RHC website (www.usac.org/rhc).

For questions assistance, contact the RHC Help Desk at 1-800-229-5476, or rhc-admin@usac.org.

¹ 47 C.F.R. 54.619(c).

From: rhcadmin@usac.org [mailto:rhcadmin@usac.org]
Sent: Wednesday, July 23, 2014 1:43 PM
To: Richard Wideman
Subject: Funding Commitment Letter (FCL) for HCP 10682, FRN 13366901

Date: 23-Jul-2014

Funding Year: 2013
Health Care Provider (HCP) Name: Stebbins Clinic
HCP Number: 10682
FCC Form 465 Application Number: 43138000
Funding Request Number: 13366901

The Rural Health Care (RHC) division of the Universal Service Administrative Company (USAC) has completed the review of the *Funding Request and Certification Form (FCC Form 466)* submitted on behalf of the Health Care Provider (HCP) named above. Based on the information provided, RHC has determined that the HCP is eligible for the estimated support listed below. Additionally, if the HCP submitted a contract or service agreement with the form, the outcome of the contract review is included in this letter.

HCP Physical Location: 50 Carabou St., Stebbins, AK, 99671
Service Type: Satellite Service
Bandwidth: 2 Mbps
Service Provider Name: GCI Communication Corp
Service Provider Identification Number (SPIN): 143001199
Billing Account Number: RH000220008

Funding Start Date	Funding End Date	Months of Support	Non-Recurring Support Amount	Monthly Recurring Support Amount	Total Support Amount	Contract Expiration Date
11-Oct-2013	30-Jun-2014	8.67742	\$0.00	\$10,041.00	\$87,129.97	08-Aug-2015

Note that the funding end date will coincide with the contract expiration date. Therefore, if the contract ends during this funding year, the HCP must participate in competitive bidding before selecting a new service provider (or continuing formerly contracted services on a month-to-month basis, or purchasing a term extension) to be eligible for funding for the entirety of the funding year.

It is the HCP's responsibility to review and verify that all information on this Funding Commitment Letter (FCL) is accurate. All account holders and the service provider listed on the form have received this FCL, and it is saved in the *My Documents* section of *My Portal*.

Contract/Service Agreement Endorsement Determination: Non-Evergreen/MTM

Non-evergreen (or month-to-month) service offering: If an HCP submits a service agreement that is not signed and dated, or if the type of service, the term, or location of service(s) are not specified, the service agreement will be designated as Non-evergreen, (month-to-month, tariffed service). The HCP must participate in competitive bidding (submit an FCC Form 465 and select the most cost-effective service and service provider) each funding year.

If, at any time, the funded services are not provided to the HCP, or the HCP is not otherwise receiving the approved funding, the HCP must notify RHC immediately.

The Billing Account Number, certifications, and all other information provided on FCC Forms 465, 466, 466-A, and 467 may be subject to audit by RHC and the FCC.¹ HCPs are subject to audits and other reviews that the RHC and/or the FCC may undertake to ensure that the universal service support is used in compliance with FCC program rules. If the funded service(s) are not used in compliance with program rules, program participants will be subject to enforcement activities and other means of recourse by RHC and other appropriate federal, state, and local authorities.

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Appeals:

Appeals must be electronically date-stamped or postmarked within 60 days of the date of this letter. Letters of appeal must contain the HCP Number, Funding Request Number(s), the SPIN, the affected funding year, and documentation of the decision being appealed (this FCL, denial letter, etc.).

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For questions assistance, contact the RHC Help Desk at 1-800-229-5476, or rhc-admin@usac.org.

¹ 47 C.F.R. 54.619(c).

From: rhcadmin@usac.org [mailto:rhcadmin@usac.org]
Sent: Wednesday, July 23, 2014 1:38 PM
To: Richard Wideman
Subject: Funding Commitment Letter (FCL) for HCP 10683, FRN 13366911

Date: 23-Jul-2014

Funding Year: 2013
Health Care Provider (HCP) Name: Teller Clinic
HCP Number: 10683
FCC Form 465 Application Number: 43138003
Funding Request Number: 13366911

The Rural Health Care (RHC) division of the Universal Service Administrative Company (USAC) has completed the review of the *Funding Request and Certification Form (FCC Form 466)* submitted on behalf of the Health Care Provider (HCP) named above. Based on the information provided, RHC has determined that the HCP is eligible for the estimated support listed below. Additionally, if the HCP submitted a contract or service agreement with the form, the outcome of the contract review is included in this letter.

HCP Physical Location: 545 Airport Ave., 72 mi NW of Nome 65.263610 North Latitude & 166.360830 West Longitude, Teller, AK, 99778
Service Type: Satellite Service
Bandwidth: 2 Mbps
Service Provider Name: GCI Communication Corp
Service Provider Identification Number (SPIN): 143001199
Billing Account Number: RH000220008

Funding Start Date	Funding End Date	Months of Support	Non-Recurring Support Amount	Monthly Recurring Support Amount	Total Support Amount	Contract Expiration Date
11-Oct-2013	30-Jun-2014	8.67742	\$0.00	\$10,041.00	\$87,129.97	08-Aug-2015

Note that the funding end date will coincide with the contract expiration date. Therefore, if the contract ends during this funding year, the HCP must participate in competitive bidding before selecting a new service provider (or continuing formerly contracted services on a month-to-month basis, or purchasing a term extension) to be eligible for funding for the entirety of the funding year.

It is the HCP's responsibility to review and verify that all information on this Funding Commitment Letter (FCL) is accurate. All account holders and the service provider listed on the form have received this FCL, and it is saved in the *My Documents* section of *My Portal*.

Contract/Service Agreement Endorsement Determination: Non-Evergreen/MTM

Non-evergreen (or month-to-month) service offering: If an HCP submits a service agreement that is not signed and dated, or if the type of service, the term, or location of service(s) are not specified, the service agreement will be designated as Non-evergreen, (month-to-month, tariffed service). The HCP must participate in competitive bidding (submit an FCC Form 465 and select the most cost-effective service and service provider) each funding year.

If, at any time, the funded services are not provided to the HCP, or the HCP is not otherwise receiving the approved funding, the HCP must notify RHC immediately.

The Billing Account Number, certifications, and all other information provided on FCC Forms 465, 466, 466-A, and 467 may be subject to audit by RHC and the FCC.¹ HCPs are subject to audits and other reviews that the RHC and/or the FCC may undertake to ensure that the universal service support is used in compliance with FCC program rules. If the funded service(s) are not used in compliance with program rules, program participants will be subject to enforcement activities and other means of recourse by RHC and other appropriate federal, state, and local authorities.

Next Steps:

Submit an FCC Form 467 (*Connection Certification*), which confirms receipt of the services for which funding has been approved, and the date on which the service provider began providing those services. Funding cannot be issued until this form is processed. To submit the FCC Form 467, go to the *My Forms* tab of *My Portal* and find the applicable Form 466 or Form 466-A and click on the "Create 467" button. Once the Form 467 is approved, the HCP and the service provider will receive a copy of the HCP Support Schedule (HSS). Receipt of the HSS means that the service provider must begin crediting the HCP for the funding amount (if it has not yet done so) and may begin to invoice USAC.

Appeals:

Appeals must be electronically date-stamped or postmarked within 60 days of the date of this letter. Letters of appeal must contain the HCP Number, Funding Request Number(s), the SPIN, the affected funding year, and documentation of the decision being appealed (this FCL, denial letter, etc.).

Additionally, FCC rule section 54.721 requires "a statement setting forth the party's interest in the matter presented for review; a full statement of relevant, material facts with supporting affidavits and documentation; the question presented for review...[and] a statement of the relief sought and the relevant statutory or regulatory provision pursuant to which such relief is sought."

Failure to include the required information in the letter of appeal or the required documentation to support the appeal may impact the appeal decision.

Detailed instructions on filing an appeal are found at: www.usac.org/rhc/about/program-integrity/appeals.aspx.

Details about and definitions of all terms used in this FCL are provided on the RHC website (www.usac.org/rhc).

For questions assistance, contact the RHC Help Desk at 1-800-229-5476, or rhc-admin@usac.org.

¹ 47 C.F.R. 54.619(c).

From: rhcadmin@usac.org [mailto:rhcadmin@usac.org]
Sent: Wednesday, July 23, 2014 1:26 PM
To: Richard Wideman
Subject: Funding Commitment Letter (FCL) for HCP 10684, FRN 13366921

Date: 23-Jul-2014

Funding Year: 2013
Health Care Provider (HCP) Name: Euksavik Clinic
HCP Number: 10684
FCC Form 465 Application Number: 43137995
Funding Request Number: 13366921

The Rural Health Care (RHC) division of the Universal Service Administrative Company (USAC) has completed the review of the *Funding Request and Certification Form (FCC Form 466)* submitted on behalf of the Health Care Provider (HCP) named above. Based on the information provided, RHC has determined that the HCP is eligible for the estimated support listed below. Additionally, if the HCP submitted a contract or service agreement with the form, the outcome of the contract review is included in this letter.

HCP Physical Location: 189 Airport Rd, Unalakleet, AK, 99684
Service Type: Satellite Service
Bandwidth: 2 Mbps
Service Provider Name: GCI Communication Corp
Service Provider Identification Number (SPIN): 143001199
Billing Account Number: RH000220008

Funding Start Date	Funding End Date	Months of Support	Non-Recurring Support Amount	Monthly Recurring Support Amount	Total Support Amount	Contract Expiration Date
09-Oct-2013	30-Jun-2014	8.74194	\$0.00	\$10,384.64	\$90,781.90	08-Aug-2015

Note that the funding end date will coincide with the contract expiration date. Therefore, if the contract ends during this funding year, the HCP must participate in competitive bidding before selecting a new service provider (or continuing formerly contracted services on a month-to-month basis, or purchasing a term extension) to be eligible for funding for the entirety of the funding year.

It is the HCP's responsibility to review and verify that all information on this Funding Commitment Letter (FCL) is accurate. All account holders and the service provider listed on the form have received this FCL, and it is saved in the *My Documents* section of *My Portal*.

Contract/Service Agreement Endorsement Determination: Non-Evergreen/MTM

Non-evergreen (or month-to-month) service offering: If an HCP submits a service agreement that is not signed and dated, or if the type of service, the term, or location of service(s) are not specified, the service agreement will be designated as Non-evergreen, (month-to-month, tariffed service). The HCP must participate in competitive bidding (submit an FCC Form 465 and select the most cost-effective service and service provider) each funding year.

If, at any time, the funded services are not provided to the HCP, or the HCP is not otherwise receiving the approved funding, the HCP must notify RHC immediately.

The Billing Account Number, certifications, and all other information provided on FCC Forms 465, 466, 466-A, and 467 may be subject to audit by RHC and the FCC.¹ HCPs are subject to audits and other reviews that the RHC and/or the FCC may undertake to ensure that the universal service support is used in compliance with FCC program rules. If the funded service(s) are not used in compliance with program rules, program participants will be subject to enforcement activities and other means of recourse by RHC and other appropriate federal, state, and local authorities.

Next Steps:

Submit an FCC Form 467 (*Connection Certification*), which confirms receipt of the services for which funding has been approved, and the date on which the service provider began providing those services. Funding cannot be issued until this form is processed. To submit the FCC Form 467, go to the *My Forms* tab of *My Portal* and find the applicable Form 466 or Form 466-A and click on the "Create 467" button. Once the Form 467 is approved, the HCP and the service provider will receive a copy of the HCP Support Schedule (HSS). Receipt of the HSS means that the service provider must begin crediting the HCP for the funding amount (if it has not yet done so) and may begin to invoice USAC.

Appeals:

Appeals must be electronically date-stamped or postmarked within 60 days of the date of this letter. Letters of appeal must contain the HCP Number, Funding Request Number(s), the SPIN, the affected funding year, and documentation of the decision being appealed (this FCL, denial letter, etc.).

Additionally, FCC rule section 54.721 requires "a statement setting forth the party's interest in the matter presented for review; a full statement of relevant, material facts with supporting affidavits and documentation; the question presented for review...[and] a statement of the relief sought and the relevant statutory or regulatory provision pursuant to which such relief is sought."

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For questions assistance, contact the RHC Help Desk at 1-800-229-5476, or rhc-admin@usac.org.

¹ 47 C.F.R. 54.619(c).

From: rhcadmin@usac.org [mailto:rhcadmin@usac.org]
Sent: Wednesday, September 17, 2014 8:41 AM
To: Richard Wideman
Subject: Funding Commitment Letter (FCL) for HCP 10684, FRN 13366921

Date: 17-Sep-2014

Funding Year: 2013
Health Care Provider (HCP) Name: Euksavik Clinic
HCP Number: 10684
FCC Form 465 Application Number: 43137995
Funding Request Number: 13366921

The Rural Health Care (RHC) division of the Universal Service Administrative Company (USAC) has completed the review of the *Funding Request and Certification Form (FCC Form 466)* submitted on behalf of the Health Care Provider (HCP) named above. Based on the information provided, RHC has determined that the HCP is eligible for the estimated support listed below. Additionally, if the HCP submitted a contract or service agreement with the form, the outcome of the contract review is included in this letter.

HCP Physical Location: 189 Airport Rd, Unalakleet, AK, 99684
Service Type: Satellite Service
Bandwidth: 2 Mbps
Service Provider Name: GCI Communication Corp
Service Provider Identification Number (SPIN): 143001199
Billing Account Number: RH000220008

Funding Start Date	Funding End Date	Months of Support	Non-Recurring Support Amount	Monthly Recurring Support Amount	Total Support Amount	Contract Expiration Date
19-Jul-2013	03-Mar-2014	7.51612	\$0.00	\$10,384.64	\$78,052.20	08-Aug-2015

Note that the funding end date will coincide with the contract expiration date. Therefore, if the contract ends during this funding year, the HCP must participate in competitive bidding before selecting a new service provider (or continuing formerly contracted services on a month-to-month basis, or purchasing a term extension) to be eligible for funding for the entirety of the funding year.

It is the HCP's responsibility to review and verify that all information on this Funding Commitment Letter (FCL) is accurate. All account holders and the service provider listed on the form have received this FCL, and it is saved in the *My Documents* section of *My Portal*.

Contract/Service Agreement Endorsement Determination: Non-Evergreen/MTM

Non-evergreen (or month-to-month) service offering: If an HCP submits a service agreement that is not signed and dated, or if the type of service, the term, or location of service(s) are not specified, the service agreement will be designated as Non-evergreen, (month-to-month, tariffed service). The HCP must participate in competitive bidding (submit an FCC Form 465 and select the most cost-effective service and service provider) each funding year.

If, at any time, the funded services are not provided to the HCP, or the HCP is not otherwise receiving the approved funding, the HCP must notify RHC immediately.

The Billing Account Number, certifications, and all other information provided on FCC Forms 465, 466, 466-A, and 467 may be subject to audit by RHC and the FCC.¹ HCPs are subject to audits and other reviews that the RHC and/or the FCC may undertake to ensure that the universal service support is used in compliance with FCC program rules. If the funded service(s) are not used in compliance with program rules, program participants will be subject to enforcement activities and other means of recourse by RHC and other appropriate federal, state, and local authorities.

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Appeals:

Appeals must be electronically date-stamped or postmarked within 60 days of the date of this letter. Letters of appeal must contain the HCP Number, Funding Request Number(s), the SPIN, the affected funding year, and documentation of the decision being appealed (this FCL, denial letter, etc.).

Additionally, FCC rule section 54.721 requires "a statement setting forth the party's interest in the matter presented for review; a full statement of relevant, material facts with supporting affidavits and documentation; the question presented for review...[and] a statement of the relief sought and the relevant statutory or regulatory provision pursuant to which such relief is sought."

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Details about and definitions of all terms used in this FCL are provided on the RHC website (www.usac.org/rhc).

For questions assistance, contact the RHC Help Desk at 1-800-229-5476, or rhc-admin@usac.org.

¹ 47 C.F.R. 54.619(c).

From: rhcadmin@usac.org [mailto:rhcadmin@usac.org]
Sent: Wednesday, July 23, 2014 1:27 PM
To: Richard Wideman
Subject: Funding Commitment Letter (FCL) for HCP 10685, FRN 13366931

Date: 23-Jul-2014

Funding Year: 2013
Health Care Provider (HCP) Name: Wales Clinic
HCP Number: 10685
FCC Form 465 Application Number: 43137990
Funding Request Number: 13366931

The Rural Health Care (RHC) division of the Universal Service Administrative Company (USAC) has completed the review of the *Funding Request and Certification Form (FCC Form 466)* submitted on behalf of the Health Care Provider (HCP) named above. Based on the information provided, RHC has determined that the HCP is eligible for the estimated support listed below. Additionally, if the HCP submitted a contract or service agreement with the form, the outcome of the contract review is included in this letter.

HCP Physical Location: 530 Snowbank St., Wales, AK, 99783
Service Type: Satellite Service
Bandwidth: 2 Mbps
Service Provider Name: GCI Communication Corp
Service Provider Identification Number (SPIN): 143001199
Billing Account Number: RH000220008

Funding Start Date	Funding End Date	Months of Support	Non-Recurring Support Amount	Monthly Recurring Support Amount	Total Support Amount	Contract Expiration Date
09-Oct-2013	30-Jun-2014	8.74194	\$0.00	\$10,041.00	\$87,777.82	08-Aug-2015

Note that the funding end date will coincide with the contract expiration date. Therefore, if the contract ends during this funding year, the HCP must participate in competitive bidding before selecting a new service provider (or continuing formerly contracted services on a month-to-month basis, or purchasing a term extension) to be eligible for funding for the entirety of the funding year.

It is the HCP's responsibility to review and verify that all information on this Funding Commitment Letter (FCL) is accurate. All account holders and the service provider listed on the form have received this FCL, and it is saved in the *My Documents* section of *My Portal*.

Contract/Service Agreement Endorsement Determination: Non-Evergreen/MTM

Non-evergreen (or month-to-month) service offering: If an HCP submits a service agreement that is not signed and dated, or if the type of service, the term, or location of service(s) are not specified, the service agreement will be designated as Non-evergreen, (month-to-month, tariffed service). The HCP must participate in competitive bidding (submit an FCC Form 465 and select the most cost-effective service and service provider) each funding year.

If, at any time, the funded services are not provided to the HCP, or the HCP is not otherwise receiving the approved funding, the HCP must notify RHC immediately.

The Billing Account Number, certifications, and all other information provided on FCC Forms 465, 466, 466-A, and 467 may be subject to audit by RHC and the FCC.¹ HCPs are subject to audits and other reviews that the RHC and/or the FCC may undertake to ensure that the universal service support is used in compliance with FCC program rules. If the funded service(s) are not used in compliance with program rules, program participants will be subject to enforcement activities and other means of recourse by RHC and other appropriate federal, state, and local authorities.

Next Steps:

Submit an FCC Form 467 (*Connection Certification*), which confirms receipt of the services for which funding has been approved, and the date on which the service provider began providing those services. Funding cannot be issued until this form is processed. To submit the FCC Form 467, go to the *My Forms* tab of *My Portal* and find the applicable Form 466 or Form 466-A and click on the "Create 467" button. Once the Form 467 is approved, the HCP and the service provider will receive a copy of the HCP Support Schedule (HSS). Receipt of the HSS means that the service provider must begin crediting the HCP for the funding amount (if it has not yet done so) and may begin to invoice USAC.

Appeals:

Appeals must be electronically date-stamped or postmarked within 60 days of the date of this letter. Letters of appeal must contain the HCP Number, Funding Request Number(s), the SPIN, the affected funding year, and documentation of the decision being appealed (this FCL, denial letter, etc.).

Additionally, FCC rule section 54.721 requires "a statement setting forth the party's interest in the matter presented for review; a full statement of relevant, material facts with supporting affidavits and documentation; the question presented for review...[and] a statement of the relief sought and the relevant statutory or regulatory provision pursuant to which such relief is sought."

Failure to include the required information in the letter of appeal or the required documentation to support the appeal may impact the appeal decision.

Detailed instructions on filing an appeal are found at: www.usac.org/rhc/about/program-integrity/appeals.aspx.

Details about and definitions of all terms used in this FCL are provided on the RHC website (www.usac.org/rhc).

For questions assistance, contact the RHC Help Desk at 1-800-229-5476, or rhc-admin@usac.org.

¹ 47 C.F.R. 54.619(c).

From: rhcadmin@usac.org [mailto:rhcadmin@usac.org]
Sent: Wednesday, July 23, 2014 1:44 PM
To: Richard Wideman
Subject: Funding Commitment Letter (FCL) for HCP 10686, FRN 13366941

Date: 23-Jul-2014

Funding Year: 2013
Health Care Provider (HCP) Name: White Mountain Clinic
HCP Number: 10686
FCC Form 465 Application Number: 43137994
Funding Request Number: 13366941

The Rural Health Care (RHC) division of the Universal Service Administrative Company (USAC) has completed the review of the *Funding Request and Certification Form (FCC Form 466)* submitted on behalf of the Health Care Provider (HCP) named above. Based on the information provided, RHC has determined that the HCP is eligible for the estimated support listed below. Additionally, if the HCP submitted a contract or service agreement with the form, the outcome of the contract review is included in this letter.

HCP Physical Location: 2 Scow John Rd., White Mountain, AK, 99784
Service Type: Satellite Service
Bandwidth: 2 Mbps
Service Provider Name: GCI Communication Corp
Service Provider Identification Number (SPIN): 143001199
Billing Account Number: RH000220008

Funding Start Date	Funding End Date	Months of Support	Non-Recurring Support Amount	Monthly Recurring Support Amount	Total Support Amount	Contract Expiration Date
09-Oct-2013	30-Jun-2014	8.74194	\$0.00	\$10,041.00	\$87,777.82	08-Aug-2015

Note that the funding end date will coincide with the contract expiration date. Therefore, if the contract ends during this funding year, the HCP must participate in competitive bidding before selecting a new service provider (or continuing formerly contracted services on a month-to-month basis, or purchasing a term extension) to be eligible for funding for the entirety of the funding year.

It is the HCP's responsibility to review and verify that all information on this Funding Commitment Letter (FCL) is accurate. All account holders and the service provider listed on the form have received this FCL, and it is saved in the *My Documents* section of *My Portal*.

Contract/Service Agreement Endorsement Determination: Non-Evergreen/MTM

Non-evergreen (or month-to-month) service offering: If an HCP submits a service agreement that is not signed and dated, or if the type of service, the term, or location of service(s) are not specified, the service agreement will be designated as Non-evergreen, (month-to-month, tariffed service). The HCP must participate in competitive bidding (submit an FCC Form 465 and select the most cost-effective service and service provider) each funding year.

If, at any time, the funded services are not provided to the HCP, or the HCP is not otherwise receiving the approved funding, the HCP must notify RHC immediately.

The Billing Account Number, certifications, and all other information provided on FCC Forms 465, 466, 466-A, and 467 may be subject to audit by RHC and the FCC.¹ HCPs are subject to audits and other reviews that the RHC and/or the FCC may undertake to ensure that the universal service support is used in compliance with FCC program rules. If the funded service(s) are not used in compliance with program rules, program participants will be subject to enforcement activities and other means of recourse by RHC and other appropriate federal, state, and local authorities.

Next Steps:

Submit an FCC Form 467 (*Connection Certification*), which confirms receipt of the services for which funding has been approved, and the date on which the service provider began providing those services. Funding cannot be issued until this form is processed. To submit the FCC Form 467, go to the *My Forms* tab of *My Portal* and find the applicable Form 466 or Form 466-A and click on the "Create 467" button. Once the Form 467 is approved, the HCP and the service provider will receive a copy of the HCP Support Schedule (HSS). Receipt of the HSS means that the service provider must begin crediting the HCP for the funding amount (if it has not yet done so) and may begin to invoice USAC.

Appeals:

Appeals must be electronically date-stamped or postmarked within 60 days of the date of this letter. Letters of appeal must contain the HCP Number, Funding Request Number(s), the SPIN, the affected funding year, and documentation of the decision being appealed (this FCL, denial letter, etc.).

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For questions assistance, contact the RHC Help Desk at 1-800-229-5476, or rhc-admin@usac.org.

¹ 47 C.F.R. 54.619(c).

ATTACHMENT 6

From: rhcadmin@usac.org [mailto:rhcadmin@usac.org]
Sent: Wednesday, July 23, 2014 1:26 PM
To: Richard Wideman
Subject: Funding Commitment Letter (FCL) for HCP 10684, FRN 13366921

Date: 23-Jul-2014

Funding Year: 2013
Health Care Provider (HCP) Name: Euksavik Clinic
HCP Number: 10684
FCC Form 465 Application Number: 43137995
Funding Request Number: 13366921

The Rural Health Care (RHC) division of the Universal Service Administrative Company (USAC) has completed the review of the *Funding Request and Certification Form (FCC Form 466)* submitted on behalf of the Health Care Provider (HCP) named above. Based on the information provided, RHC has determined that the HCP is eligible for the estimated support listed below. Additionally, if the HCP submitted a contract or service agreement with the form, the outcome of the contract review is included in this letter.

HCP Physical Location: 189 Airport Rd, Unalakleet, AK, 99684
Service Type: Satellite Service
Bandwidth: 2 Mbps
Service Provider Name: GCI Communication Corp
Service Provider Identification Number (SPIN): 143001199
Billing Account Number: RH000220008

Funding Start Date	Funding End Date	Months of Support	Non-Recurring Support Amount	Monthly Recurring Support Amount	Total Support Amount	Contract Expiration Date
09-Oct-2013	30-Jun-2014	8.74194	\$0.00	\$10,384.64	\$90,781.90	08-Aug-2015

Note that the funding end date will coincide with the contract expiration date. Therefore, if the contract ends during this funding year, the HCP must participate in competitive bidding before selecting a new service provider (or continuing formerly contracted services on a month-to-month basis, or purchasing a term extension) to be eligible for funding for the entirety of the funding year.

It is the HCP's responsibility to review and verify that all information on this Funding Commitment Letter (FCL) is accurate. All account holders and the service provider listed on the form have received this FCL, and it is saved in the *My Documents* section of *My Portal*.

Contract/Service Agreement Endorsement Determination: Non-Evergreen/MTM

Non-evergreen (or month-to-month) service offering: If an HCP submits a service agreement that is not signed and dated, or if the type of service, the term, or location of service(s) are not specified, the service agreement will be designated as Non-evergreen, (month-to-month, tariffed service). The HCP must participate in competitive bidding (submit an FCC Form 465 and select the most cost-effective service and service provider) each funding year.

If, at any time, the funded services are not provided to the HCP, or the HCP is not otherwise receiving the approved funding, the HCP must notify RHC immediately.

The Billing Account Number, certifications, and all other information provided on FCC Forms 465, 466, 466-A, and 467 may be subject to audit by RHC and the FCC.¹ HCPs are subject to audits and other reviews that the RHC and/or the FCC may undertake to ensure that the universal service support is used in compliance with FCC program rules. If the funded service(s) are not used in compliance with program rules, program participants will be subject to enforcement activities and other means of recourse by RHC and other appropriate federal, state, and local authorities.

Next Steps:

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Appeals:

Appeals must be electronically date-stamped or postmarked within 60 days of the date of this letter. Letters of appeal must contain the HCP Number, Funding Request Number(s), the SPIN, the affected funding year, and documentation of the decision being appealed (this FCL, denial letter, etc.).

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For questions assistance, contact the RHC Help Desk at 1-800-229-5476, or rhc-admin@usac.org.

¹ 47 C.F.R. 54.619(c).

ATTACHMENT 7

From: rhcadmin@usac.org [mailto:rhcadmin@usac.org]
Sent: Wednesday, September 17, 2014 8:41 AM
To: Richard Wideman
Subject: Funding Commitment Letter (FCL) for HCP 10684, FRN 13366921

Date: 17-Sep-2014

Funding Year: 2013
Health Care Provider (HCP) Name: Euksavik Clinic
HCP Number: 10684
FCC Form 465 Application Number: 43137995
Funding Request Number: 13366921

The Rural Health Care (RHC) division of the Universal Service Administrative Company (USAC) has completed the review of the *Funding Request and Certification Form (FCC Form 466)* submitted on behalf of the Health Care Provider (HCP) named above. Based on the information provided, RHC has determined that the HCP is eligible for the estimated support listed below. Additionally, if the HCP submitted a contract or service agreement with the form, the outcome of the contract review is included in this letter.

HCP Physical Location: 189 Airport Rd, Unalakleet, AK, 99684
Service Type: Satellite Service
Bandwidth: 2 Mbps
Service Provider Name: GCI Communication Corp
Service Provider Identification Number (SPIN): 143001199
Billing Account Number: RH000220008

Funding Start Date	Funding End Date	Months of Support	Non-Recurring Support Amount	Monthly Recurring Support Amount	Total Support Amount	Contract Expiration Date
19-Jul-2013	03-Mar-2014	7.51612	\$0.00	\$10,384.64	\$78,052.20	08-Aug-2015

Note that the funding end date will coincide with the contract expiration date. Therefore, if the contract ends during this funding year, the HCP must participate in competitive bidding before selecting a new service provider (or continuing formerly contracted services on a month-to-month basis, or purchasing a term extension) to be eligible for funding for the entirety of the funding year.

It is the HCP's responsibility to review and verify that all information on this Funding Commitment Letter (FCL) is accurate. All account holders and the service provider listed on the form have received this FCL, and it is saved in the *My Documents* section of *My Portal*.

Contract/Service Agreement Endorsement Determination: Non-Evergreen/MTM

Non-evergreen (or month-to-month) service offering: If an HCP submits a service agreement that is not signed and dated, or if the type of service, the term, or location of service(s) are not specified, the service agreement will be designated as Non-evergreen, (month-to-month, tariffed service). The HCP must participate in competitive bidding (submit an FCC Form 465 and select the most cost-effective service and service provider) each funding year.

If, at any time, the funded services are not provided to the HCP, or the HCP is not otherwise receiving the approved funding, the HCP must notify RHC immediately.

The Billing Account Number, certifications, and all other information provided on FCC Forms 465, 466, 466-A, and 467 may be subject to audit by RHC and the FCC.¹ HCPs are subject to audits and other reviews that the RHC and/or the FCC may undertake to ensure that the universal service support is used in compliance with FCC program rules. If the funded service(s) are not used in compliance with program rules, program participants will be subject to enforcement activities and other means of recourse by RHC and other appropriate federal, state, and local authorities.

Next Steps:

Submit an FCC Form 467 (*Connection Certification*), which confirms receipt of the services for which funding has been approved, and the date on which the service provider began providing those services. Funding cannot be issued until this form is processed. To submit the FCC Form 467, go to the *My Forms* tab of *My Portal* and find the applicable Form 466 or Form 466-A and click on the "Create 467" button. Once the Form 467 is approved, the HCP and the service provider will receive a copy of the HCP Support Schedule (HSS). Receipt of the HSS means that the service provider must begin crediting the HCP for the funding amount (if it has not yet done so) and may begin to invoice USAC.

Appeals:

Appeals must be electronically date-stamped or postmarked within 60 days of the date of this letter. Letters of appeal must contain the HCP Number, Funding Request Number(s), the SPIN, the affected funding year, and documentation of the decision being appealed (this FCL, denial letter, etc.).

Additionally, FCC rule section 54.721 requires "a statement setting forth the party's interest in the matter presented for review; a full statement of relevant, material facts with supporting affidavits and documentation; the question presented for review...[and] a statement of the relief sought and the relevant statutory or regulatory provision pursuant to which such relief is sought."

Failure to include the required information in the letter of appeal or the required documentation to support the appeal may impact the appeal decision.

Detailed instructions on filing an appeal are found at: www.usac.org/rhc/about/program-integrity/appeals.aspx.

Details about and definitions of all terms used in this FCL are provided on the RHC website (www.usac.org/rhc).

For questions assistance, contact the RHC Help Desk at 1-800-229-5476, or rhc-admin@usac.org.

¹ 47 C.F.R. 54.619(c).

ATTACHMENT 8

Health Care Providers Universal Service Funding Request and Certification Form

The Deadline to submit this Form is the June 30th End of the Funding Year.

Estimated time per response: 3 hours

Read instructions thoroughly before completing this form. Failure to comply may cause delayed or denied funding.**Block 1: HCP Information**

1 HCP Name Euksavik Clinic	2 HCP Number 10684
3 Form 465 Application # 43137995	4 Consortium Name (If any)

Block 2: Bill Payer Information

5 Billed Entity Name Euksavik Clinic	6 Billed Entity FCC RN 0014835128
7 Contact Name Richard B Wideman	
8 Address Line 1 P O Box 189	
9 Address Line 2	
10 City Unalakleet	11 State AK 12 Zip 99684
13 Contact Phone # 9074433272	14 Fax # 15 E-Mail rwideman@nshcorp.org

Block 3: Funding Year Information

16 Funding Year - Check only one box		
<input checked="" type="checkbox"/> Year 2013 (7/1/2013-6/30/2014)	<input type="checkbox"/> Year 2014 (7/1/2014-6/30/2015)	<input type="checkbox"/> Year 2015 (7/1/2015-6/30/2016)

Block 4: Service Information

17 Type of Service & Circuit Bandwidth (Enclose documentation.) MPLS 8 Mbps	
18 Total Billed Miles 0	19 Maximum Allowable Distance (From Form 465) 400
20 Percentage of HCP's service used for the provision of health care. 100 (If less than 100%, please explain.) If the HCP indicated it is a part-time eligible entity (on Form 465), describe method of allocating prorated support.	

Connection Information	Carrier A	Carrier B	Carrier C	Carrier D
21 Service Provider Name	GCI Communication Corp			
22 Service Provider Identification Number (SPIN)	143031199			
23 Service Provider Contact Person Name	Steve Walker			
24 Service Provider Contact Person's Phone #	(907) 868-6416			
25 Service Provider Contact Person Email	swalker@gci.com			
26 Circuit Start Location	189 Airport Road Unalakleet, AK 99684			
27 Circuit Termination Location	1000 Greg Kruschak Ave Nome, AK 99762			
28 Billing Account Number	RH000220006			
29 Tariff, Contract or other document reference number	HC-302-1			
30 Date Contract Signed or Date HCP Selected Carrier	31-Jan-2014			
31 Contract Expiration Date (mm/dd/yyyy or NA if MTM)	08-Aug-2015			
32 Service Installation Date	04-Mar-2014			
33 Actual Rural Rate per Month (Enclose Documentation)	66963.00			
34 If you are a consortium member OR have multiple carriers, please attach a Circuit Diagram to show how the sites interconnect and which carrier(s) provides each circuit segment. Circuit Diagram included: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
35 Are you a mobile rural health care provider? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, see instructions and attach a list of all sites to be served.				

IF YOU ARE REQUESTING SUPPORT FOR MILEAGE-BASED CHARGES, COMPLETE BLOCK 5 ONLY AND SKIP BLOCK 6. (PLEASE SEE INSTRUCTIONS). IF YOU ARE REQUESTING SUPPORT BASED ON URBAN/RURAL RATE COMPARISON, SKIP BLOCK 5 AND COMPLETE ONLY BLOCK 6. YOUR APPLICATION CANNOT BE PROCESSED IF BOTH BLOCKS ARE COMPLETED.				
Block 5: Mileage-based Charge Discount Request				
Complete this block if you are seeking support for mileage (distance-based) charges only. Do not enter any other charges in this block. You may need to ask your service provider representative to provide this information.				
36 Billed Circuit Miles				
37 Monthly Mileage Charges (Exclude Channel Termination chgs, etc.)				
38 Cost per Mile per Month				
If Line 33 equals Line 37, please ensure that ONLY mileage-related charges are included in Line 37. (See instructions.)				
Block 6: Comprehensive Rate Comparison Request				
Complete Block 6 if you have not completed Block 5 and are requesting support for all elements of your telecommunications service necessary for the provision of health care. The information in this block will establish the difference between the urban and rural rates for your requested service. Please call RHCD at 1-800-229-5476 if you need assistance.				
39 One-time Urban Rate Charge (in selected large city)	0			
40 One-time Rural Rate Charge (in city where HCP is located)	0			
41 Monthly Urban Rate (in selected large city). From RHCD web site: <input type="checkbox"/> or Other rate documentation attached: <input checked="" type="checkbox"/>	272.00			
If your circuit includes charges for mileage over the Maximum Allowable Dist., (Line 19), please complete Lines 42 to 44. Otherwise, skip to Block 7.				
42 Billed Circuit Miles				
43 Monthly Mileage Based Charges				
44 Cost per Mile per Month				
Block 7: Bid Documentation				
45 Did you receive any bids in response to the Form 465 Request for Services posted on the RHCD website? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If you checked yes, copies of the bids MUST be mailed to RHCD.				
Block 8: Certification				
46 <input checked="" type="checkbox"/> I certify that the above named entity has considered all bids received and selected the most cost-effective method of providing the requested service or services. The "most cost-effective service" is defined in the Universal Service Order as the service available at the lowest cost after consideration of the features, quality of transmission, reliability, and other factors that the health care provider deems necessary for the service to adequately transmit the health care services required by the health care provider.				
47 <input checked="" type="checkbox"/> Pursuant to 47 C.F.R. Secs. 54.601 and 54.603, I certify that the HCP or consortium that I am representing satisfies all of the requirements herein and will abide by all of the relevant requirements, including all applicable FCC rules, with respect to universal service benefits provided under 47 U.S.C. Sec. 254. I understand that any letter from RHCD that erroneously states that funds will be made available for the benefit of the applicant may be subject to rescission.				
48 <input checked="" type="checkbox"/> I hereby certify that the billed entity will maintain complete billing records for the service for five years.				
49 <input checked="" type="checkbox"/> I certify that I am authorized to submit this request on behalf of the above-named Billed Entity and HCP, and that I have examined this form and attachments and that to the best of my knowledge, information, and belief, all statements of fact contained herein are true.				
50 Signature Electronically signed		51 Date 28-Apr-2014		
52 Printed name of authorized person Richard B Wideman		53 Title or position of authorized person TeleHealth Coordinator		
54 Employer of authorized person Norton Sound Health Corporation		55 Employer's FCC RN 0014835128		

Please remember:

- You must submit one Form 466 for **each service** (i.e., circuit) for which you request reduced rates. For example:
 - If you are requesting reduced rates for **two** T1 lines, you must submit **two** Forms 466.
 - If you are requesting reduced rates for **two** ISDN lines & **one** Frame Relay line, you must submit **three** Forms 466.
- **If the service described on this form is subject to the 28-day competitive bidding requirement, do not select a carrier or complete the Form 466 before or during the 28-day posting period.**
- **You must provide evidence of the urban rate if you have completed Block 6 and have not used the urban rates from the website.**
- This form, attachments, and supporting documents should be combined in one envelope and sent to the RHCD.
- If the service described on this form changes (e.g., rate change) during the funding year, **you must notify RHCD immediately** and submit a revised Form 466.
- If you have any questions, call RHCD at 1-800-229-5476.

Persons willfully making false statements on this form can be punished by fine or forfeiture under the Communications Act, 47 U.S.C. Secs. 502, 503(b), or fine or imprisonment under Title 18 of the United States Code, 18 U.S.C. Sec. 1001.

FCC NOTICE FOR INDIVIDUALS REQUIRED BY THE PRIVACY ACT AND THE PAPERWORK REDUCTION ACT

Part 3 of the Commission's Rules authorize the FCC to request the information on this form. The data reported will be used to ensure that health care providers have selected the most cost-effective method of providing the requested services as set forth in 47 C.F.R. § 54.603(b)(4). The information will be used by the Universal Service Administrative Company and/or the staff of the Federal Communications Commission, to evaluate this form, to provide information for enforcement and rulemaking proceedings and to maintain a current inventory of applicants, health care providers, billed entities, and service providers. No authorization can be granted unless all information requested is provided. Failure to provide all requested information will delay the processing of the application or result in the application being returned without action. Information requested by this form will be available for public inspection. Your response is required to obtain the requested authorization.

The public reporting for this collection of information is estimated to average 3 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the required data, and completing and reviewing the collection of information. If you have any comments on this burden estimate, or how we can improve the collection and reduce the burden it causes you, please write to the Federal Communications Commission, AMD-PER, Paperwork Reduction Act Project (3060-0804), Washington, DC 20554. We will also accept your comments regarding the Paperwork Reduction Act aspects of this collection via the Internet if you send them to pra@fcc.gov. **PLEASE DO NOT SEND YOUR RESPONSE TO THIS ADDRESS.**

Remember - You are not required to respond to a collection of information sponsored by the Federal government, and the government may not conduct or sponsor this collection, unless it displays a currently valid OMB control number or if we fail to provide you with this notice. This collection has been assigned an OMB control number of 3060-0804.

THE FOREGOING NOTICE IS REQUIRED BY THE PRIVACY ACT OF 1974, PUBLIC LAW 93-579, DECEMBER 31, 1974, 5 U.S.C. 552a(e)(3) AND THE PAPERWORK REDUCTION ACT OF 1995, PUBLIC LAW 104-13, OCTOBER 1, 1995, 44 U.S.C. SECTION 3507.

This form should be submitted to:

Rural Health Care Division
30 Lanidex Plaza West, P.O.Box 685
Parsippany NJ 07054-0685

ATTACHMENT 9

From: rhcadmin@usac.org [mailto:rhcadmin@usac.org]
Sent: Wednesday, September 10, 2014 10:24 AM
To: Richard Wideman
Subject: Funding Commitment Letter (FCL) for HCP 10684, FRN 13429421

Date: 10-Sep-2014

Funding Year: 2013
Health Care Provider (HCP) Name: Euksavik Clinic
HCP Number: 10684
FCC Form 465 Application Number: 43137995
Funding Request Number: 13429421

The Rural Health Care (RHC) division of the Universal Service Administrative Company (USAC) has completed the review of the *Funding Request and Certification Form (FCC Form 466)* submitted on behalf of the Health Care Provider (HCP) named above. Based on the information provided, RHC has determined that the HCP is eligible for the estimated support listed below. Additionally, if the HCP submitted a contract or service agreement with the form, the outcome of the contract review is included in this letter.

HCP Physical Location: 189 Airport Rd, Unalakleet, AK, 99684

Service Type: MPLS

Bandwidth: 8 Mbps

Service Provider Name: GCI Communication Corp

Service Provider Identification Number (SPIN): 143001199

Billing Account Number: RH000220008

Funding Start Date	Funding End Date	Months of Support	Non-Recurring Support Amount	Monthly Recurring Support Amount	Total Support Amount	Contract Expiration Date
04-Mar-2014	30-Jun-2014	3.90323	\$0.00	\$66,711.00	\$260,388.38	08-Aug-2015

Note that the funding end date will coincide with the contract expiration date. Therefore, if the contract ends during this funding year, the HCP must participate in competitive bidding before selecting a new service provider (or continuing formerly contracted services on a month-to-month basis, or purchasing a term extension) to be eligible for funding for the entirety of the funding year.

It is the HCP's responsibility to review and verify that all information on this Funding Commitment Letter (FCL) is accurate. All account holders and the service provider listed on the form have received this FCL, and it is saved in the *My Documents* section of *My Portal*.

Contract/Service Agreement Endorsement Determination: Non-Evergreen/MTM

Non-evergreen (or month-to-month) service offering: If an HCP submits a service agreement that is not signed and dated, or if the type of service, the term, or location of service(s) are not specified, the service agreement will be designated as Non-evergreen, (month-to-month, tariffed service). The HCP must participate in competitive bidding (submit an FCC Form 465 and select the most cost-effective service and service provider) each funding year.

If, at any time, the funded services are not provided to the HCP, or the HCP is not otherwise receiving the approved funding, the HCP must notify RHC immediately.

The Billing Account Number, certifications, and all other information provided on FCC Forms 465, 466, 466-A, and 467 may be subject to audit by RHC and the FCC.¹ HCPs are subject to audits and other reviews that the RHC and/or the FCC may undertake to ensure that the universal service support is used in compliance with FCC program rules. If the funded service(s) are not used in compliance with program rules, program participants will be subject to enforcement activities and other means of recourse by RHC and other appropriate federal, state, and local authorities.

Next Steps:

Submit an FCC Form 467 (*Connection Certification*), which confirms receipt of the services for which funding has been approved, and the date on which the service provider began providing those services. Funding cannot be issued until this form is processed. To submit the FCC Form 467, go to the *My Forms* tab of *My Portal* and find the applicable Form 466 or Form 466-A and click on the "Create 467" button. Once the Form 467 is approved, the HCP and the service provider will receive a copy of the HCP Support Schedule (HSS). Receipt of the HSS means that the service provider must begin crediting the HCP for the funding amount (if it has not yet done so) and may begin to invoice USAC.

Appeals:

Appeals must be electronically date-stamped or postmarked within 60 days of the date of this letter. Letters of appeal must contain the HCP Number, Funding Request Number(s), the SPIN, the affected funding year, and documentation of the decision being appealed (this FCL, denial letter, etc.).

Additionally, FCC rule section 54.721 requires "a statement setting forth the party's interest in the matter presented for review; a full statement of relevant, material facts with supporting affidavits and documentation; the question presented for review...[and] a statement of the relief sought and the relevant statutory or regulatory provision pursuant to which such relief is sought."

Failure to include the required information in the letter of appeal or the required documentation to support the appeal may impact the appeal decision.

Detailed instructions on filing an appeal are found at: www.usac.org/rhc/about/program-integrity/appeals.aspx.

Details about and definitions of all terms used in this FCL are provided on the RHC website (www.usac.org/rhc).

For questions assistance, contact the RHC Help Desk at 1-800-229-5476, or rhc-admin@usac.org.

¹ 47 C.F.R. 54.619(c).

ATTACHMENT 10

SKK 3Mbps

FCC Form

Health Care Providers Universal Service

Approval by OMB

466

Funding Request and Certification Form

3060-0804

The Deadline to submit this Form is the June 30th End of the Funding Year.

Estimated time per response: 3 hours

Read instructions thoroughly before completing this form. Failure to comply may cause delayed or denied funding.

Block 1: HCP Information

1 HCP Name Shaktoolik Clinic	2 HCP Number 10680
3 Form 465 Application # 43137992	4 Consortium Name (If any)

Block 2: Bill Payer Information

5 Billed Entity Name Shaktoolik Clinic	6 Billed Entity FCC RN 0014835128
7 Contact Name Richard B Wideman	
8 Address Line 1 P O Box 09	
9 Address Line 2	
10 City Shaktoolik	11 State AK 12 Zip 99771
13 Contact Phone # 9074433272	14 Fax # 15 E-Mail rwideman@nshcorp.org

Block 3: Funding Year Information

16 Funding Year - Check only one box
☒ Year 2013 (7/1/2013-6/30/2014) ☐ Year 2014 (7/1/2014-6/30/2015) ☐ Year 2015 (7/1/2015-6/30/2016)

Block 4: Service Information

17 Type of Service & Circuit Bandwidth (Enclose documentation.) MPLS 3 Mbps
18 Total Billed Miles 0 19 Maximum Allowable Distance (From Form 465) 424
20 Percentage of HCP's service used for the provision of health care. 100 (If less than 100%, please explain.) If the HCP indicated it is a part-time eligible entity (on Form 465), describe method of allocating prorated support. _____ _____ _____ _____

Connection Information	Carrier A	Carrier B	Carrier C	Carrier D
21 Service Provider Name	GCI Communication Corp			
22 Service Provider Identification Number (SPIN)	143091199			
23 Service Provider Contact Person Name	Steve Walker			
24 Service Provider Contact Person's Phone #	(907) 868-6416			
25 Service Provider Contact Person Email	swalker@gci.com			
26 Circuit Start Location	9 Ocean View Rd Shaktoolik, AK 99771			
27 Circuit Termination Location	1000 Greg Kruschek Ave Nome, AK 99762			
28 Billing Account Number	RH600220008			
29 Tariff, Contract or other document reference number	HC-302			
30 Date Contract Signed or Date HCP Selected Carrier	08-Aug-2010			
31 Contract Expiration Date (mm/dd/yyyy or NA if MTM)	08-Aug-2015			
32 Service Installation Date	12-Feb-2014			
33 Actual Rural Rate per Month (Enclose Documentation)	26449.00			
34 If you are a consortium member OR have multiple carriers, please attach a Circuit Diagram to show how the sites interconnect and which carrier(s) provides each circuit segment. Circuit Diagram included: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
35 Are you a mobile rural health care provider? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, see instructions and attach a list of all sites to be served.				

FCC Form 466

November 2012

IF YOU ARE REQUESTING SUPPORT FOR MILEAGE-BASED CHARGES, COMPLETE BLOCK 5 ONLY AND SKIP BLOCK 6. (PLEASE SEE INSTRUCTIONS). IF YOU ARE REQUESTING SUPPORT BASED ON URBAN/RURAL RATE COMPARISON, SKIP BLOCK 5 AND COMPLETE ONLY BLOCK 6. YOUR APPLICATION CANNOT BE PROCESSED IF BOTH BLOCKS ARE COMPLETED.

Block 5: Mileage-based Charge Discount Request

Complete this block if you are seeking support for mileage (distance-based) charges only. Do not enter any other charges in this block. You may need to ask your service provider representative to provide this information.

36 Billed Circuit Miles				
37 Monthly Mileage Charges (Exclude Channel Termination chgs, etc.)				
38 Cost per Mile per Month				

If Line 33 equals Line 37, please ensure that ONLY mileage-related charges are included in Line 37. (See instructions.)

Block 6: Comprehensive Rate Comparison Request

Complete Block 6 if you have not completed Block 5 and are requesting support for all elements of your telecommunications service necessary for the provision of health care. The information in this block will establish the difference between the urban and rural rates for your requested service.

Please call RHCD at 1-800-229-5476 if you need assistance.

39 One-time Urban Rate Charge (in selected large city)	0.00			
40 One-time Rural Rate Charge (in city where HCP is located)	0			
41 Monthly Urban Rate (in selected large city). From RHCD web site: <input type="checkbox"/> or Other rate documentation attached: <input checked="" type="checkbox"/>	196.00			

If your circuit includes charges for mileage over the Maximum Allowable Dist., (Line 19), please complete Lines 42 to 44. Otherwise, skip to Block 7.

42 Billed Circuit Miles				
43 Monthly Mileage Based Charges				
44 Cost per Mile per Month				

Block 7: Bid Documentation

45 Did you receive any bids in response to the Form 465 Request for Services posted on the RHCD website? ☐ Yes ☒ No
If you checked yes, copies of the bids MUST be mailed to RHCD.

Block 8: Certification

46 <input checked="" type="checkbox"/> I certify that the above named entity has considered all bids received and selected the most cost-effective method of providing the requested service or services. The "most cost-effective service" is defined in the Universal Service Order as the service available at the lowest cost after consideration of the features, quality of transmission, reliability, and other factors that the health care provider deems necessary for the service to adequately transmit the health care services required by the health care provider.	
47 <input checked="" type="checkbox"/> Pursuant to 47 C.F.R. Secs. 54.601 and 54.603, I certify that the HCP or consortium that I am representing satisfies all of the requirements herein and will abide by all of the relevant requirements, including all applicable FCC rules, with respect to universal service benefits provided under 47 U.S.C. Sec. 254. I understand that any letter from RHCD that erroneously states that funds will be made available for the benefit of the applicant may be subject to rescission.	
48 <input checked="" type="checkbox"/> I hereby certify that the billed entity will maintain complete billing records for the service for five years.	
49 <input checked="" type="checkbox"/> I certify that I am authorized to submit this request on behalf of the above-named Billed Entity and HCP, and that I have examined this form and attachments and that to the best of my knowledge, information, and belief, all statements of fact contained herein are true.	
50 Signature Electronically signed	51 Date 28-Apr-2014
52 Printed name of authorized person Richard B Wideman	53 Title or position of authorized person TeleHealth Coordinator
54 Employer of authorized person Norton Sound Health Corporation	55 Employer's FCC RN 0014835128

Please remember:

- You must submit one Form 466 for **each service** (i.e., circuit) for which you request reduced rates. For example:
 - If you are requesting reduced rates for **two T1 lines**, you must submit **two** Forms 466.
 - If you are requesting reduced rates for **two ISDN lines & one Frame Relay line**, you must submit **three** Forms 466.
- If the service described on this form is subject to the 28-day competitive bidding requirement, do not select a carrier or complete the Form 466 before or during the 28-day posting period.
- You must provide evidence of the urban rate if you have completed Block 6 and have not used the urban rates from the website.
- This form, attachments, and supporting documents should be combined in one envelope and sent to the RHCD.
- If the service described on this form changes (e.g., rate change) during the funding year, you must notify RHCD immediately and submit a revised Form 466.
- If you have any questions, call RHCD at 1-800-229-5476.

Persons willfully making false statements on this form can be punished by fine or forfeiture under the Communications Act, 47 U.S.C. Secs. 502, 503(b), or fine or imprisonment under Title 18 of the United States Code, 18 U.S.C. Sec. 1001.

FCC NOTICE FOR INDIVIDUALS REQUIRED BY THE PRIVACY ACT AND THE PAPERWORK REDUCTION ACT

Part 3 of the Commission's Rules authorize the FCC to request the information on this form. The data reported will be used to ensure that health care providers have selected the most cost-effective method of providing the requested services as set forth in 47 C.F.R. § 54.603(b)(4). The information will be used by the Universal Service Administrative Company and/or the staff of the Federal Communications Commission, to evaluate this form, to provide information for enforcement and rulemaking proceedings and to maintain a current inventory of applicants, health care providers, billed entities, and service providers. No authorization can be granted unless all information requested is provided. Failure to provide all requested information will delay the processing of the application or result in the application being returned without action. Information requested by this form will be available for public inspection. Your response is required to obtain the requested authorization.

The public reporting for this collection of information is estimated to average 3 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the required data, and completing and reviewing the collection of information. If you have any comments on this burden estimate, or how we can improve the collection and reduce the burden it causes you, please write to the Federal Communications Commission, AMD-PER, Paperwork Reduction Act Project (3060-0804), Washington, DC 20554. We will also accept your comments regarding the Paperwork Reduction Act aspects of this collection via the Internet if you send them to pra@fcc.gov. PLEASE DO NOT SEND YOUR RESPONSE TO THIS ADDRESS.

Remember - You are not required to respond to a collection of information sponsored by the Federal government, and the government may not conduct or sponsor this collection, unless it displays a currently valid OMB control number or if we fail to provide you with this notice. This collection has been assigned an OMB control number of 3060-0804.

THE FOREGOING NOTICE IS REQUIRED BY THE PRIVACY ACT OF 1974, PUBLIC LAW 93-579, DECEMBER 31, 1974, 5 U.S.C. 552a(e)(3) AND THE PAPERWORK REDUCTION ACT OF 1995, PUBLIC LAW 104-13, OCTOBER 1, 1995, 44 U.S.C. SECTION 3507.

This form should be submitted to:
Rural Health Care Division
30 Lanidex Plaza West, P.O.Box 685
Parsippany NJ 07054-0685

ATTACHMENT 11

From: rhcadmin@usac.org [mailto:rhcadmin@usac.org]
Sent: Wednesday, July 23, 2014 1:38 PM
To: Richard Wideman
Subject: Funding Commitment Letter (FCL) for HCP 10680, FRN 13429371

Date: 23-Jul-2014

Funding Year: 2013
Health Care Provider (HCP) Name: Shaktoolik Clinic
HCP Number: 10680
FCC Form 465 Application Number: 43137992
Funding Request Number: 13429371

The Rural Health Care (RHC) division of the Universal Service Administrative Company (USAC) has completed the review of the *Funding Request and Certification Form (FCC Form 466)* submitted on behalf of the Health Care Provider (HCP) named above. Based on the information provided, RHC has determined that the HCP is eligible for the estimated support listed below. Additionally, if the HCP submitted a contract or service agreement with the form, the outcome of the contract review is included in this letter.

HCP Physical Location: 9 Ocean View Rd., Shaktoolik, AK, 99771
Service Type: MPLS
Bandwidth: 3 Mbps
Service Provider Name: GCI Communication Corp
Service Provider Identification Number (SPIN): 143001199
Billing Account Number: RH000220008

Funding Start Date	Funding End Date	Months of Support	Non-Recurring Support Amount	Monthly Recurring Support Amount	Total Support Amount	Contract Expiration Date
12-Feb-2014	30-Jun-2014	4.60714	\$0.00	\$26,253.00	\$120,951.25	08-Aug-2015

Note that the funding end date will coincide with the contract expiration date. Therefore, if the contract ends during this funding year, the HCP must participate in competitive bidding before selecting a new service provider (or continuing formerly contracted services on a month-to-month basis, or purchasing a term extension) to be eligible for funding for the entirety of the funding year.

It is the HCP's responsibility to review and verify that all information on this Funding Commitment Letter (FCL) is accurate. All account holders and the service provider listed on the form have received this FCL, and it is saved in the *My Documents* section of *My Portal*.

Contract/Service Agreement Endorsement Determination: Non-Evergreen/MTM

Non-evergreen (or month-to-month) service offering: If an HCP submits a service agreement that is not signed and dated, or if the type of service, the term, or location of service(s) are not specified, the service agreement will be designated as Non-evergreen, (month-to-month, tariffed service). The HCP must participate in competitive bidding (submit an FCC Form 465 and select the most cost-effective service and service provider) each funding year.

If, at any time, the funded services are not provided to the HCP, or the HCP is not otherwise receiving the approved funding, the HCP must notify RHC immediately.

The Billing Account Number, certifications, and all other information provided on FCC Forms 465, 466, 466-A, and 467 may be subject to audit by RHC and the FCC.¹ HCPs are subject to audits and other reviews that the RHC and/or the FCC may undertake to ensure that the universal service support is used in compliance with FCC program rules. If the funded service(s) are not used in compliance with program rules, program participants will be subject to enforcement activities and other means of recourse by RHC and other appropriate federal, state, and local authorities.

Next Steps:

Submit an FCC Form 467 (*Connection Certification*), which confirms receipt of the services for which funding has been approved, and the date on which the service provider began providing those services. Funding cannot be issued until this form is processed. To submit the FCC Form 467, go to the *My Forms* tab of *My Portal* and find the applicable Form 466 or Form 466-A and click on the "Create 467" button. Once the Form 467 is approved, the HCP and the service provider will receive a copy of the HCP Support Schedule (HSS). Receipt of the HSS means that the service provider must begin crediting the HCP for the funding amount (if it has not yet done so) and may begin to invoice USAC.

Appeals:

Appeals must be electronically date-stamped or postmarked within 60 days of the date of this letter. Letters of appeal must contain the HCP Number, Funding Request Number(s), the SPIN, the affected funding year, and documentation of the decision being appealed (this FCL, denial letter, etc.).

Additionally, FCC rule section 54.721 requires "a statement setting forth the party's interest in the matter presented for review; a full statement of relevant, material facts with supporting affidavits and documentation; the question presented for review...[and] a statement of the relief sought and the relevant statutory or regulatory provision pursuant to which such relief is sought."

Failure to include the required information in the letter of appeal or the required documentation to support the appeal may impact the appeal decision.

Detailed instructions on filing an appeal are found at: www.usac.org/rhc/about/program-integrity/appeals.aspx.

Details about and definitions of all terms used in this FCL are provided on the RHC website (www.usac.org/rhc).

For questions assistance, contact the RHC Help Desk at 1-800-229-5476, or rhc-admin@usac.org.

¹ 47 C.F.R. 54.619(c).

ATTACHMENT 12



USAC Rural Health Care

Competitive Bidding Requirements

April 20, 2011

Steps to Successful Competitive Bidding

1. Fill out the Form 465 clearly, accurately, and in a timely manner
2. Develop selection criteria to review bids
3. Wait 29 days before submitting a Form 466/466A, indicating bid selection (note the Allowable Contract Selection Date – or ACSD)
4. Submit contract to USAC for Evergreen review (optional) with Form 466/466A

1. Form 465

When completing the Form 465 (Description of Services Requested & Certification Form):

- **Be careful** of what is listed on Line 29!

29 Please describe the eligible health care provider's telecommunications and/or Internet service needs, so that service providers may bid to provide the services. The description should describe whether video or store and forward consultations will be used, whether large image files or X-rays will be transmitted, the quality of connection needed, or other relevant considerations.

1. Form 465

- We recommend you do NOT request a specific telecom service and/or bandwidth
 - **TOO SPECIFIC:** We need a T1 line
- Instead you should describe the needs of the HCP:
 - **PREFERRED:** We need to be able to transmit data and medical images
- Being too specific locks you into receiving that service type only

1. Form 465

When completing the Form 465 (Description of Services Requested & Certification Form):

- Choose “Both Telecommunications & Internet Services” in Block 5 unless you’re positive you’ll use only one

Block 5: Request for Services

30 Is the HCP requesting reduced rates for:

☒ Both Telecommunications & Internet Services ☐ Telecommunications Service ONLY ☐ Internet Service ONLY


2. Selection Criteria

- HCPs should develop a plan to evaluate bids prior to reviewing submitted proposals to determine how they will select the most cost-effective service provider
 - Cost-effective defined by the FCC as “the method of least cost after consideration of the features, quality of transmission, reliability, and other factors relevant to choosing a method of providing the required services.”

2. Selection Criteria

- USAC encourages the use of an (optional) scoring tool/scoring matrix
 - HCPs should choose the selection criteria most important to them. Some examples include but are not limited to:
 - Technical support
 - Previous experience with service provider
 - Cost for service
 - Rapid response
 - Service provider to provide a single point of contact

3. 28 days

- Once the applicant is deemed eligible, the complete Form 465 is posted on RHC website:
 Required 28-day posting period begins
- During this time, service providers may contact HCPs and submit proposals
- HCPs must not enter into a contract or service agreement until the Allowable Contract Selection Date (ACSD), or the 29th day after the 465 is posted

- The ACSD is listed under “Posted Services” on the RHC website, under “Rural Health Care Tools” (<http://usac.org/rhc/service-providers/step02/>)

Rural Health Care
Health Care Providers
Service Providers

Rural Health Care Search Tools

About Rural Health Care:

- Overview of the Program
- Overview of the Process
- Monthly Conference Calls
- Individual Outreach
- Understanding Audits
- Training Events
- Filing Appeals
- FCC Links
- Rural Health Care Pilot Program

Rural Health Care Tools:

- Applicant Login
- Latest News
- Required Forms
- Tips and Best Practices
- Frequently Asked Questions
- Glossary of Terms
- Rural Health Care Search Tools**

Rural Health Care Search Tools

- Health Care Provider (HCP) Login
- Search Posted Services**
- Packet Status Report
- Automated Search of Commitments
- Urban Rate
- List of Eligible Rural Areas

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3. 28 days

- The ACSD is listed under “Posted Services” on the RHC website, under “Rural Health Care Tools” (<http://usac.org/rhc/service-providers/step02/>)

Count	HCP Number	HCP Name	City	County	State	Posting Date	Allowable Contract Date
1	11537	Davenport Clinic	Davenport	VA-Buchanan	VA	4/5/2011	5/3/2011
2	11540	Eastern Shore Rural Health System, Inc. - Nassawadox	Nassawadox	VA-Norfolk	VA	4/7/2011	5/5/2011
3	11543	Haysi Clinic	Haysi	VA-Dickinson	VA	4/5/2011	5/3/2011
4	12798	William A. Davis Clinic	St. Paul	VA-Russell	VA	4/5/2011	5/3/2011

3. 28 days

- Submit Form 465 as early as possible after window opens
 - Allow time to review bids
 - Allow time before start of fund year to ensure full year of funding

4. Evergreen Contracts

What is an Evergreen Contract?

- An “evergreen” contract is a valid contract that has been reviewed and endorsed by USAC
- HCPs with evergreen contracts are not required to post a Form 465 or re-bid for those services for the life of the contract

4. Evergreen Contracts

What Makes a Contract “Evergreen?”

- Contains two authorized signatures (HCP and SP)
- Contract is dated (after the Allowable Contract Selection Date – i.e. after the 28 days)
- Contract specifies the service type(s), terms, and cost of service(s)
- Identifies (all) HCP location(s) within the contract
- Contract is submitted and reviewed by USAC
 - USAC will notify applicants whether the contract is endorsed as evergreen, month-to-month, or neither

4. Evergreen Contracts

Important Considerations for HCPs:

- Your contract must be reviewed and deemed to be evergreen by USAC; otherwise, you **MUST** post a Form 465 each year
- If you receive notification that you have an evergreen contract, you should list the contract end date on Line 29 so that service providers know when to contact you to bid on upcoming service needs, whether it is during the current funding year or future fund years
- If services or contract terms change in any way, HCPs must post a new Form 465 and go through the competitive bidding process again

4. Evergreen Contracts

Important Considerations for Service Providers:

- Contracts cannot be deemed evergreen without review and approval by USAC
 - If you are the current service provider and the contract has not been endorsed as evergreen, the HCP must re-bid the following fund year – even if you have a signed contract
 - HCPs must entertain bids from service providers if their contract has not been deemed evergreen by USAC
 - Service providers may seek to confirm that the HCP has an evergreen contract endorsed by USAC

Reminders...

- Submit the Form 465 early (window opens between March and April) to ensure a full year of funding
- Avoid submitting incomplete/inaccurate forms and documentation
- Make sure you're aware of the ACSD – contact RHC if you're uncertain *before* entering into a service agreement
- Do not assume a contract is evergreen without formal RHC confirmation
 - First time applicants with an existing contract should call the RHC Customer Support Center (1.800.229.5476)

Keep documentation and contact information for audit

purposes:

- If audited, an HCP must be able to produce decision-making records for up to five years after the end of the funding year
- A service provider must provide documentation for five years after the end of service
- The inability to locate documentation and demonstrate fair and open competitive bidding could result in the requirement to return funds

Keep documentation and contact information for audit

purposes:

- Important documentation related to competitive bidding includes anything that would help an auditor retrace your steps in how you made your decision
 - Scoring tools/matrix
 - E-mails
 - Copy of RFP
 - Phone log



Contact Information

Customer Support Center

(800) 229-5476

Rhc-Admin@usac.org